For Office Use Only
Chart Number:____________
Reviewed by:____________

SPECTRUM MEDICAL PHYSICAL THERAPY
PAIN & SYMPTOMS QUESTIONNAIRE

Name: ___________________________________ Age:___ Date:______ Email:__________________________

What is your present condition and/or mechanism of injury? ____
____

What is your primary concern or chief complaint? ____
____

How would you describe your pain? ____

What makes the pain worse? ____
____

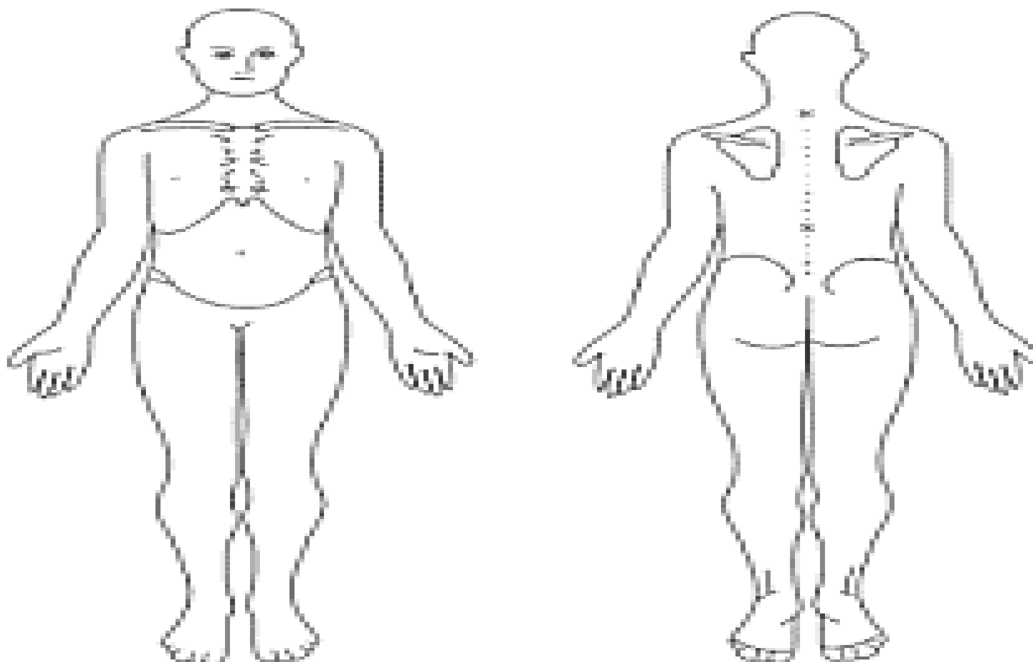
What eases your pain? ____
____

Rate the pain of your primary concern on the following scale by circling the number that best corresponds.

0 = None 5 = Moderate 10 = Extreme

Current Pain:	0	1	2	3	4	5	6	7	8	9	10
Best:	0	1	2	3	4	5	6	7	8	9	10
Worst:	0	1	2	3	4	5	6	7	8	9	10

Indicate where your pain is located and what type of pain you feel at the present time.



Please check **all** that apply to your medical history:

- ❑ Osteoarthritis
- ❑ Cardiovascular Disease
- ❑ Diabetes Mellitus Type 1
- ❑ Diabetes Mellitus Type 2
- ❑ Allergies
- ❑ Complication Factors
- ❑ Surgical History
- ❑ Previous Physical Therapy for this concern
- ❑ Psycho-Social
- ❑ History of Cancer
- ❑ Current Infection
- ❑ Immunosuppression
- ❑ Fracture or Suspected Fracture
- ❑ Cauda Equina Syndrome
- ❑ Diagnostic Testing (MRI, X-Ray, etc)
- ❑

If you checked any of the above boxes, please explain. ____
____
____
____

How would you rate your overall general health? (Circle the **one** that applies best.)

Good Fair Poor

Please state your goal of physical therapy: ____
____

By signing below, I consent to a physical therapy evaluation and treatment.

Patient Signature: ____ Date: ________

SPECTRUM MEDICAL

NAME: ______________________________________ CHART #: __________________________ DATE: ___________________

THE LOWER EXTREMITY FUNCTIONAL SCALE

We are interested in knowing whether you are having any difficulty at all with the activities listed below because of your lower limb Problem for which you are currently seeking attention. Please provide an answer for **each** activity.

Today, do you or would you have any difficulty at all with:

	Activities	Extreme Difficulty or Unable to Perform Activity	Quite a Bit of Difficulty	Moderate Difficulty	A Little Bit of Difficulty	No Difficulty
1	Any of your usual work, housework, or school activities.	0	1	2	3	4
2	Your usual hobbies, re creational or sporting activities.	0	1	2	3	4
3	Getting into or out of the bath.	0	1	2	3	4
4	Walking between rooms.	0	1	2	3	4
5	Putting on your shoes or socks.	0	1	2	3	4
6	Squatting.	0	1	2	3	4
7	Lifting an object, like a bag of groceries from the floor.	0	1	2	3	4
8	Performing light activities around your home.	0	1	2	3	4
9	Performing heavy activities around your home.	0	1	2	3	4
10	Getting into or out of a car.	0	1	2	3	4
11	Walking 2 blocks.	0	1	2	3	4
12	Walking a mile.	0	1	2	3	4
13	Going up or down 10 stairs (about 1 flight of stairs).	0	1	2	3	4
14	Standing for 1 hour.	0	1	2	3	4
15	Sitting for 1 hour.	0	1	2	3	4
16	Running on even ground.	0	1	2	3	4
17	Running on uneven ground.	0	1	2	3	4
18	Making sharp turns while running fast.	0	1	2	3	4
19	Hopping.	0	1	2	3	4
20	Rolling over in bed.	0	1	2	3	4
	Column Totals:					

Minimum Level of Detectable Change (90% Confidence): 9 points **SCORE: _____/ 80**

Please submit the sum of responses.

Reprinted from Binkley, J., Stratford, P., Lott, S., Riddle, D., & The North American Orthopaedic Rehabilitation Research Network, The Lower Extremity Functional Scale: Scale development, measurement properties, and clinical application, Physical Therapy, 1999, 79, 4371-383, with permission of the American Physical Therapy Association.

PATIENT INITIALS: ______________________