



Tranquillity Physical Therapy, Inc.

Making a Difference in Patient's Rehabilitation Care.

Patient Questionnaire

Welcome to Tranquillity! To provide you with the best, most comprehensive care possible, we request that you provide the following information. All information is held strictly confidential and is released only with your written permission.

Name _____

Referring Physician _____

Date _____ Onset Date: _____

Pain Rating

0	1	2	3	4	5	6	7	8	9	10
No Pain		Moderate			Strong		Very Strong		Emergency	

Chose the number from the above pain rating chart that best describes the severity of your pain

On the average _____ At its best _____ At its worst _____

What percentage of the day you have pain or discomfort?

0% 20% 40% 60% 80% 100%

Is your pain worse in the _____ Morning _____ Evening _____ Both _____ Other?

Explain _____

Describe or illustrate your symptoms on the diagram using these symbols

//// Stabbing XXXX Burning 000 Pins and Needles = = = Numbness >>>>> Shooting

Other description of your symptoms _____

Work History

Do you work or did you work at the time of illness? _____ Yes _____ No.

If yes answer the following. What is/was you job title? _____

Which work task affects your pain? _____

Are you currently on disability? _____ Yes _____ No.

	Doctor Notes <i>Please do not write in this area</i>
Presenting Problem or Proposed Surgery: _____ _____ _____	



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Have you had any of the following:					
	Yes	No		Yes	No
Allergies, asthma, hay fever			Migraine Headaches		
Anemia			Rheumatic Fever		
Alcoholism			Stroke		
Arthritis			Suicide Attempts		
Bleeding problems			Thyroid Disease/Goiter		
Birth defects			Tuberculosis		
Cancer			Ulcers		
Emphysema			Venereal Disease		
Epilepsy or seizures			Osteoporosis		
Heart Trouble			Glaucoma		
Mental illness			Gall Stones		
Names of Other Present Physicians			Last Visit		
ALLERGIES: Please list type and reaction NONE					
Name of Drug/Item	Reaction		Name of Drug/Item	Reaction	

What current medications are you currently taking?
Please List Name of Medication, Dosage, and Frequency:

Blood pressure pills _____	Antibiotics _____
Cortisone/steroids _____	Blood Thinners _____
Diabetes pills _____	Laxatives _____
Thyroid pills _____	Pain Medications _____
Tranquilizers _____	Sleeping pill _____
Water pills _____	Vitamins _____
Aspirin _____	Other Please List: _____

Past Medical History:

Surgeries	Date	Major Illnesses or Injury	Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Patient Signature

Date