ST. FRANCIS
Regional Medical Center

Patient Questionnaire

Name: _____ Date of Birth: _____

Email address: _____ Receive mail and email from us? Y / N

How did you hear from us (please circle):
Doctor referral Family/friend recommendation Website search

What are we seeing you for today? _____
How and when did this problem start? _____

_____

Because of your problem, what specific activities are you having difficulty with?

_____
_____

What goals/outcomes would you like to achieve from therapy? _____

_____

Have you sought previous treatment for your condition? (check all that apply)

___ Physical/Occupational/Speech Therapy ___Chiropractor
___Injections ___Massage therapy ___Other: _____

What diagnostic tests have you had for this problem (X-ray, MRI, EMG, etc?): _____
_____

Have you had any therapy in the last year? _____

Surgical History (include year if able): _____
_____

Is this a worker's compensation injury? Y / N
Is this a motor vehicle accident? Y / N
Are you currently receiving home care services? Y / N

Please list any restrictions your doctor has given you (i.e. lifting, driving): _____

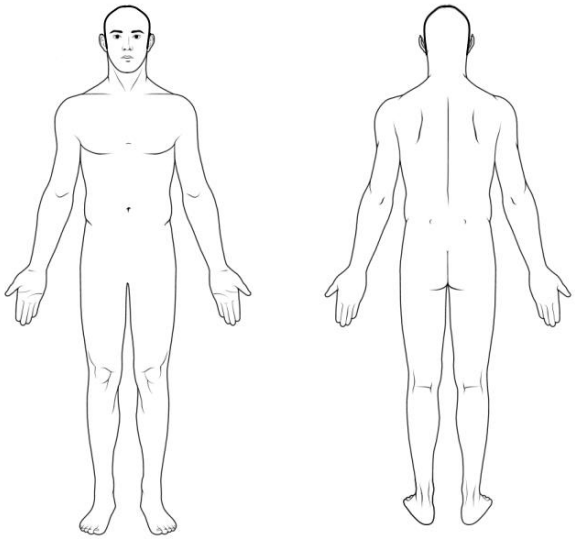
_____

When are you scheduled to see your doctor again? _____

Occupation: _____

Please complete both sides.

Please rate your pain (0 = no pain, 10 = worst pain imaginable):
Today's pain: _____ Worst pain: _____ Acceptable pain rating: _____
Please shade the painful areas on the diagram below.



Describe your pain:
___Constant
___Intermittent
___Dull
___Sharp
___Throbbing
___Numbness
___Tingling
___Burning

Have you recently experienced any significant changes in:
__ Mood
__Interest or pleasure in daily activities
__Unexpected loss/gain of weight
__Sleeping habits
__Recurrent thoughts of death or harming yourself
__Energy level (restlessness, lethargy, or fatigue)

Any communication or learning barriers we should know about? _____

If you receive your medical care within Allina, you can SKIP this section:

Medical History (check all that apply):

High blood pressure	Pacemaker	Stroke	Cancer	Fractures
Heart disease	Metal implants	Diabetes	Seizures	Pregnancy
Infectious disease	Visual issues	Hearing issues		Other

Current Medications (include dosage if able): _____
_____
_____

Allergies (include reactions): _____

Patient Signature _____ Date _____

Provider Signature _____ Date _____

Please complete both sides.