Berman
PHYSICAL THERAPY
DR. JAKE BERMAN, PT, DPT

Patient Questionnaire

(This information is kept confidential)

Name_____

Date _____

Gender _____ Age_____ DOB _____

How did you hear about us? _____

1. **Present Condition**

   a. What are the current symptoms of the problem(s) for which you are seeking treatment?

      Location:

      Frequency:

      Type (achy, burning, shooting, sharp, dull, radiating, etc):

   b. Circle the number indicating your pain level:

Best:	0	1	2	3	4	5	6	7	8	9	10
Current:	0	1	2	3	4	5	6	7	8	9	10
Worst:	0	1	2	3	4	5	6	7	8	9	10
	No pain										Unbearable pain

   c. What makes your symptoms worse?

   d. What makes your symptoms better?

   e. Are you currently taking any medication for your symptoms? What? How much?

   f. What does this pain keep you from doing?

   g. What do you think initially caused your symptoms? When?

2. **Current history of complaint**

   a. Have you ever had anything similar before?

   b. How often has it reoccurred?

   c. Is the frequency or severity increasing?

   d. Do you feel this problem limits your daily activities?

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3. **Please list all medical conditions and/or health concerns including history of cancer, seizures, night sweats, unexplained weight loss, strokes**

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4. **Please list all current medications:**

_____

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_____

5. Please list all previous surgeries and dates:

_____

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