



Patient Progress Evaluation Questionnaire

Patient Name: _____ Date: _____

Date of Birth: _____ Body Weight: _____

Describe your current condition being treated by PT: _____

Current medications: _____

What is your current exercise regimen? _____

How often do you exercise weekly? _____

Pain is described by:

Aching Burning Constant Cramping Deep Dull Heavy
 Numb Stabbing Throbbing Variable Weak Pins/ Needles

Pain is aggravated by:

Carrying item Lifting heavy weight Lifting anything Bending Climbing stairs Dressing/ Grooming
 Getting out of Bed Cooking Reaching Back Raising arms overhead Looking Up Lying Flat
 Pulling Twisting Walking Sitting

Pain is eased by: Ice Heat Medication Lying Flat Stretching Exercise Rest

Does your daily routine or work aggravate your injury or condition?

No 1x/week 2x/week 3x/week 4+x/week Unable to participate in regular routine

Does your injury/ condition impact your ability to do your job?

Retired Prevents me from working I can only work part-time I work with minor difficulty
 I work with great difficulty Does not impact my ability to work

Does your injury/ condition impact your ability to attend school?

N/A Prevents me from attending school Attends school, large impact
 Attends school, minor impact School is normal, can't participate in sports No restrictions

What is/are your goal(s) to accomplish with physical therapy? _____

How would you rate your progress toward accomplishing the goal(s)? (0-100%) _____

1 Patient/ Guardian Signature _____

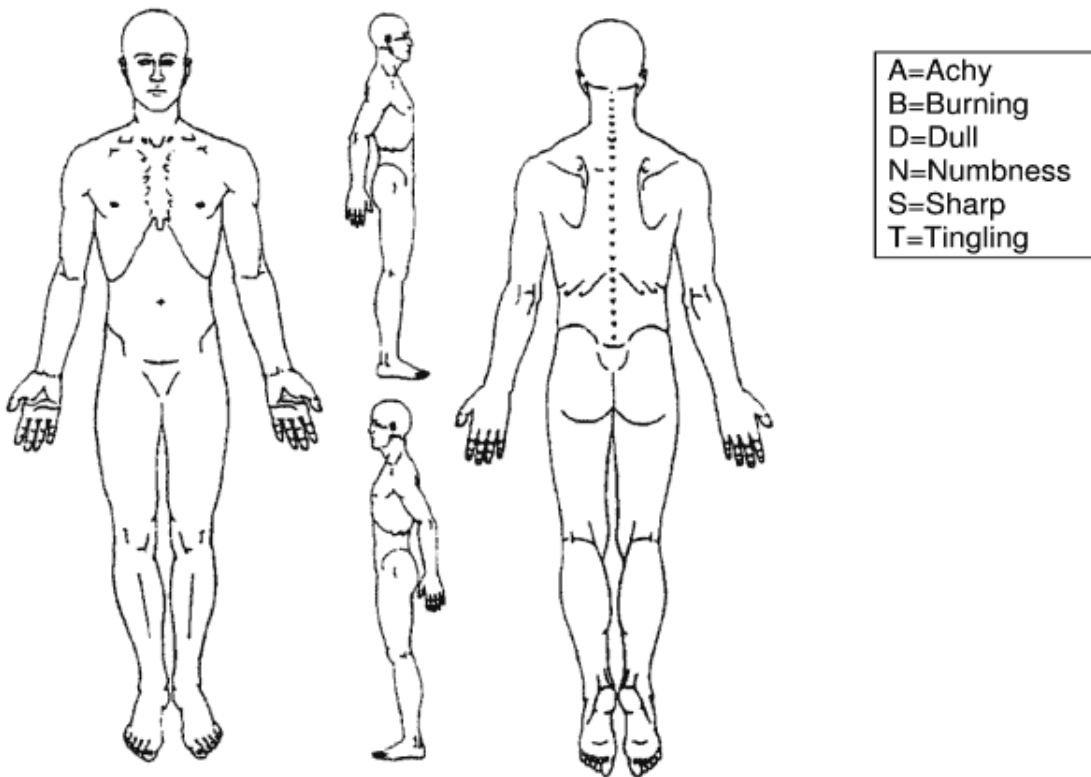
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Pain Diagram and Rating

Please choose the symbol(s) in the box that describes the type of pain or sensation you are currently experiencing and draw it on the diagram where you experience it.



Please mark the **severity of pain** (Visual Analog Pain Severity Scale):

- **Current pain:** 0 1 2 3 4 5 6 7 8 9 10
- **Worst pain in last week:** 0 1 2 3 4 5 6 7 8 9 10
- **Least pain in last week:** 0 1 2 3 4 5 6 7 8 9 10