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Patient Pre-Appointment Questionnaire (Version 07/11/2018)

Name …… **Date of birth** ……../……../…….

Home telephone number …….. **Mobile telephone number** ……..

Email Address……

Please complete the questions below (by circling the correct response) before your physiotherapy consultation. These responses will be analysed by you physiotherapist.

The questionnaire should only take you 5 to 10 minutes to complete, thank you (If you have difficulty answering a question, please leave blank and discuss later with your physiotherapist).

QUESTIONS ABOUT YOUR CURRENT PROBLEM

Please indicate by circling the appropriate number how much pain you are experiencing when at its worst

No pain 0 1 2 3 4 5 6 7 8 9 10 Extreme pain

Are your symptoms getting; better / same / worse

Have you had a similar problem in the past? Yes / No

If yes please provide relevant details: ……

……

……

Have you had previous treatment for this condition from the following: Physiotherapist / chiropractor/ osteopath / GP / sports therapist?

If so please confirm when……

……

Have you had any of the following investigations; X-Ray / MRI / ultrasound / nerve conduction studies / blood tests?

If applicable please provide approximate dates and findings if known……

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……

……

Do you have…

Unexplained weight loss?	**Yes / No**
Loss of sensation to the area of the buttocks, between your legs or inner surfaces of the thighs?	**Yes / No**
Bladder or bowel problems?	**Yes / No**
Weakness or difficulties with walking such as struggling to pick up foot?	**Yes / No**
Loss of appetite?	**Yes / No**
A current fever?	**Yes / No**
Night sweats?	**Yes / No**
If night sweats, do you feel that these are age related?	**Yes / No**

<u>QUESTIONS ABOUT YOUR NECK CIRCULATION</u> – ***PLEASE <u>IGNORE THIS SECTION</u> IF NOT COMPLAINING OF A NECK OR HEAD PROBLEM***

Do you experience…

Headaches on one side of your head?	**Yes / No**
Dizziness?	**Yes / No**
Swallowing problems?	**Yes / No**
Nausea?	**Yes / No**
Unexplained falls?	**Yes / No**
Passing out?	**Yes / No**
Vision problems?	**Yes / No**
Speech problems?	**Yes / No**
Hearing disturbance?	**Yes / No**
Reduced hand dexterity?	**Yes / No**

<u>OTHER SPECIFIC QUESTIONS ABOUT YOUR LIMBS / JOINTS</u>

Do you have muscle fatigue or weakness?	**Yes / No**
Noticeable colder areas?	**Yes / No**
Joints that lock?	**Yes / No**
Joints that click?	**Yes / No**
Joints that feel unstable?	**Yes / No**
Bruising?	**Yes / No**
Areas of warmth?	**Yes / No**
Areas of paleness?	**Yes / No**
Areas of discolouration?	**Yes / No**
Does coughing or sneezing increase your pains?	**Yes / No**

<u>QUESTIONS ABOUT THE DAILY PATTERN OF PAIN</u>

Is your pain worse in morning / afternoon / end of day / no daily pattern / no pain?

Do you wake from night pain? **Yes / No**

If night pain is this every night / most nights / occasional nights?

Can this be made better by changing position in bed? **Yes / No**

<u>QUESTIONS ABOUT YOUR PAST MEDICAL HISTORY</u>

Do you consider your general health to be good / fair / poor?

Are you under the care of any of the following specialists; Consultant Rheumatologist / Consultant Orthopaedics / Vascular specialist / Pain Clinic?

Do you have or have you been diagnosed with the following any of the following?

Asthma	**Yes / No**
Unstable epilepsy	**Yes / No**
Diabetes	**Yes / No**
Cardiovascular disease or heart problems	**Yes / No**
A hearing aid	**Yes / No**
Breathing problems	**Yes / No**
Pacemaker	**Yes / No**
Osteoporosis or osteopenia	**Yes / No**
TB or past TB	**Yes / No**
Rheumatoid arthritis	**Yes / No**
Inflammatory arthritis	**Yes / No**
High blood pressure	**Yes / No**
Low blood pressure	**Yes / No**
Peripheral vascular disease	**Yes / No**
Thyroid problems	**Yes / No**
Vitamin B12 deficiency	**Yes / No**
Increased cholesterol levels	**Yes / No**
A blood disorder such as hepatitis, haemophilia	**Yes / No**
Previous or existing cancer	**Yes / No**

Please list any operations/ significant accidents/illnesses and approximate dates:

……

……

……

……

If applicable, are you pregnant or actively trying for a pregnancy? Yes / No

Are you a smoker? Yes / No

<u>QUESTIONS ABOUT YOUR MEDICATION</u>

Have you ever taken steroids? Yes / No
If steroids are you still taking these Yes / No
Are you taking anti-coagulants? Yes / No
If applicable, do you take HRT? Yes / No

Please list your current medication(s)

……

……

……

……

Do you have any allergies Yes / No

If yes please list……

QUESTIONS ABOUT YOUR SOCIAL HISTORY

If you have a job please can provide your occupation……

If applicable, are your current symptoms preventing you from working? Yes / No
Please list any leisure activities that you are trying to return to;

…….

Please list your expectations from physiotherapy;

…….

…….

Signature of person completing form……

Name of person completing the form……

Date of completion: ……/……/……

QUESTIONNAIRE END – THANK YOU – PLEASE GIVE THIS TO YOUR PHYSIOTHERAPIST – FOR CONFIDENTIAILITY PLEASE DO NOT EMAIL OR POST THIS FORM

Please leave below blank