PHYSIOTHERAPY & SPORTS INJURY CLINIC

MUSCULOSKELETAL PHYSIOTHERAPY SERVICE

PATIENT ASSESSMENT QUESTIONNAIRE

Name: ……

Date of birth: ……

Gender: M F

Address:……
……

Email Address: ……..

Telephone Numbers:
Home:……Mobile:……

GP
Name/Practice:……
…….

Who recommended that you have Physiotherapy: GP □ Consultant □ Self □ Other □

Please complete all sections below:

How did you find out about our service?	
Why have you sought help now?	
Occupation	
Activity Levels - Competitive/Recreational (Past & Present)	
Activity (Past & Present)	
Please provide as much detail as possible in the section below	

Current Symptoms / Complaints Please provide a brief overview of the symptoms that you experience including: • - Location of symptoms: • - Onset of symptoms: • - History & onset of symptoms: • - How this impacts your daily life: • - Medical Investigations due to symptoms:	

General Levels of Stress How are your stress levels in general? Do your symptoms flare up when you are more stressed? What do you do to decrease your stress levels?	
Sleep Regular Sleeping pattern? Do you wake in the night? How do you feel upon waking - rested/ groggy?	
Energy Levels During the Day Does your energy stay consistent during the day or do you experience a slump in energy on a daily basis? If you experience a slump, do you seek anything to help you through that (caffeine/ sugar/nap)	
Major / Minor Operations or Scars Please list all operations and surgical procedures/investigations that you have undergone in chronological order. Please also list which side of the body was operated on. (Example: Left knee ACL repair)	
Imaging & Further Investigations Please detail any imaging or medical investigations that you have had done in the past, including location that was examined, reason for the investigation to be ordered and results of the investigation.	
Piercings & Tattoos Please list any piercings (even if since removed) and tattoos	

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Broken Bones Please list any fractures you have previously suffered, including any greenstick fractures as a young child. If you are not sure if an area of your body has previously suffered a fracture (not investigated at the time) please include also.	
Road Traffic Accidents Have you been involved in any RTA's in the past? Please include any incidents even if you were a pedestrian/cyclist.	
Heavy Falls Concussions, knocked out, heavy impacts to the head, falls on tail bone / coccyx, winded, climbing trees as a child, falls while horse riding, cycling or whilst playing sport	
Work Position In a corner, only interact with colleagues on one side, uneven desk position, screen etc.	
Previous Treatment Physiotherapy, podiatry, massage therapy, osteopathy, chiropractic , doctor, acupuncture etc. What types of therapy did you prefer and why?	
The following section needs to be completed by female participants only	
Child Birth How many children, natural or C-Section, Premature, late, complications, any tearing, stitches, episiotomy, breech birth etc.	
Menstrual Cycle Regular, irregular, effected by stress, effect on symptoms, any contraceptive pills current or previous, affects sleep, early / late puberty	

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Please tick any of the below and provide any relevant information	
Use of Orthotics?	
Ankle Sprains Please include all previous injuries (even from childhood)	
Achilles Tendon Injuries / Pain	
Shin Splints	
Low back pain? Spinal disc herniation?	
Knee Injuries Pain, operations, any changes and during which activity?	
Hamstring Injuries Including symptoms	
Groin Injuries / Tightness Falls on crossbar of bike, horse riding saddle impact. Males, please include any testicular pain, aches, torsions	
Pelvis Injuries Pain, SIJ Pubic Symphysis, Coccyx Injury	
Appendix Scars	
Sports Hernia / Abdominal Hernia	
Hip Injuries Tightness, symptoms, limited range of motion in one hip or both?	
Rib Injuries Bruised / fractured (Have any of these injuries been confirmed medically / X- Rays)	
Difficulty Breathing When, where, doing what, and if when stressed	
Mid-Back Symptoms Tightness, which side and when? spinal disc herniation?	
Shoulder Blades Do you have any pain in this area?	

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Shoulder Injuries Please detail the mechanism of injury. Does the pain refer anywhere else? Have you had any imaging for this problem?	
Collar-Bones Have you suffered any heavy falls on shoulder or outstretched arm? Have you suffered any heavy impacts to this area during sports or in a road traffic accident?	
Wrist Fractures, dislocations, ligament or cartilage injuries, pain or range of movement problems?	
Hand(s) Symptoms Is your grip strength the same on both hands? If not, when did you notice it had changed? Do you experience and Pins and needles or numbness in your hands or fingers during the day, during specific activities, or at night?	
Neck Injures, whiplash, 'seized' concussion, chronic tension, where, which activities, headaches, referral patterns, eye socket, temple, one sided, consistence, changes, migraines, spinal disc herniation?	
Trouble Swallowing Do you have trouble swallowing? Do you experience difficulty in swallowing your food?	
Chemical Irritant: Do you have any reactions to chemical products used in your home such as gels, deodorants, washing powder? Please list your daily or commonly used products.	
• Digestive Problems: Do you feel bloated, lethargic or an increase in discomfort after eating, after eating certain foods? • Have you been diagnosed or investigated for any digestive conditions? Do you have any known food or drink sensitivities? Do you experience certain reactions to foods or drinks that you consume?	
• Emotions: Have you suffered any emotional trauma in your past? • Were there any emotional events in your past where everything changed?	

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	Please share only what you feel comfortable sharing. If you wish to speak about this in person, please indicate this in the box adjacent. All Details provided are strictly confidential.	

Your general health – please tick if you have any of the following:

Any major illness/health problem?

Unexplained weight loss?

History of cancer?

Rheumatoid Arthritis?

Diabetes?

Epilepsy?

Heart problems? Pacemaker?

Thyroid Problems?

Pregnancy (current)?

Blood pressure problems ?

Any surgery/operations?

Chest/breathing problems?

Previous fractures?

Steroids?

Osteoporosis?

Anticoagulants?

Any other joint problems?

Any bladder/bowel symptoms changes?

Dizziness?

Please give details:

_____

_____

_____

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Please list any medications that you are taking or bring a print out of your current prescription:

_____

_____

_____

I……confirm that the information provided above is correct to the best of my knowledge. I give my consent to the physiotherapy assessment and treatment of my problem. (This may be withdrawn at any time during this period).

Patient signature…….Date…….

Are you completing this form on behalf of someone? Yes/No

If so please state your name and relationship to this patient