PATIENT INITIAL QUESTIONNAIRE

TAOS
Therapeutic Associates Outcomes System

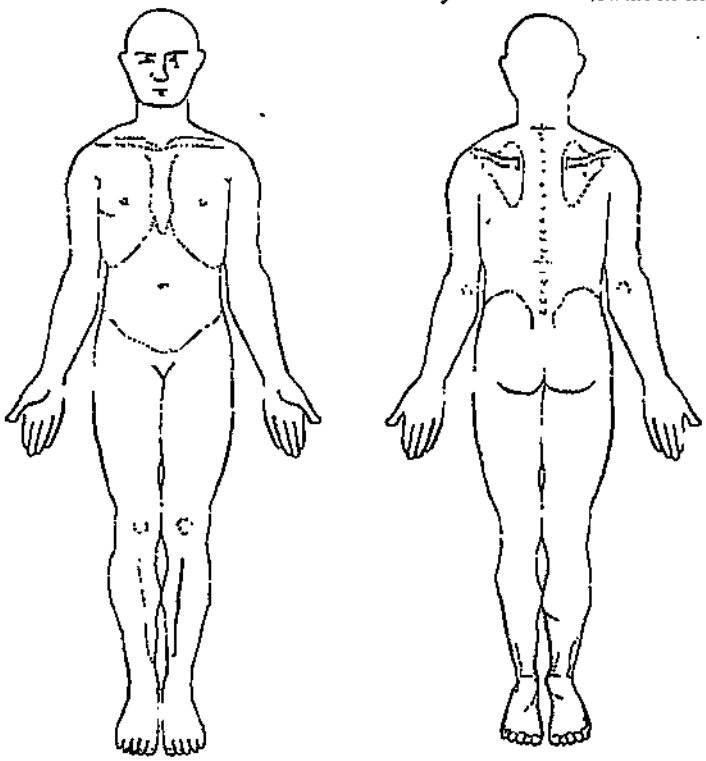
NAME _____

DATE _____

This form contains a series of questions designed to help your Physical Therapist evaluate your condition, track how you feel, and determine how well you are able to do your usual activities. This information will help your therapist and referring physician give you the best possible care. Please answer every question as accurately and completely as you can.

1. What are your symptoms? _____

Localize areas of pain or abnormal sensation on the body chart below *(Shade in where appropriate)*



2. Was the onset of this episode gradual or sudden? *(Check one)*

☐ *(A)* Gradual ☐ *(B)* Sudden

3. How long has this episode of symptoms lasted with symptoms occurring at least part of every day? *(Check one)*

☐ *(A)* Less than 1 week ☐ *(C)* 6 weeks - 3 months ☐ *(E)* Greater than 1 year
☐ *(B)* 1 - 6 weeks ☐ *(D)* 3 months - 1 year

4. When did you **first** notice this episode of symptoms *(Please indicate a specific date if possible)*? _____

5. Which of the following best describes how your injury occurred? *(Check one)*

☐ *(A)* lifting ☐ *(F)* degenerative process ☐ *(K)* a dental appointment
☐ *(B)* a MVA (car accident) ☐ *(G)* during recreation/sports ☐ *(L)* throwing
☐ *(C)* a fall ☐ *(H)* running ☐ *(M)* unknown
☐ *(D)* cumulative trauma (overuse) ☐ *(I)* a blow to the face ☐ *(N)* Other: _____
☐ *(E)* trauma ☐ *(J)* being hit by a ball _____

6. Since onset of this episode, are your symptoms getting: *(Check one).*

☐ *(A)* Better ☐ *(B)* Worse ☐ *(C)* Not changing

7. How many times have you had similar symptoms to your current problem in the past? *(Count episodes that lasted at least one day, but eventually went away completely.) (Check one)*

☐ *(A)* None previously ☐ *(B)* 1 - 5 episodes ☐ *(C)* More than 5 episodes

8. Have you ever had an operation on the body region associated with your current symptoms? *(Check one)*

☐ *(A)* No ☐ *(B)* Yes, once ☐ *(C)* Yes, more than once

If "yes", was your most recent surgery within the past six months?

☐ *(B)* Yes ☐ *(A)* No

Nature of Pain *(Check all that apply)*

- ☐ (A) sharp
- ☐ (B) dull
- ☐ (C) throbbing
- ☐ (D) aching
- ☐ (E) periodic
- ☐ (F) occasional
- ☐ (G) constant
- ☐ (H) other: _____

). During the past four weeks, have you used any pain medication for your current symptoms?.

☐ (A) Yes ☐ (B) No

.. Does the pain wake you at night?.

☐ (A) No

If "yes", is it present.

- ☐ (A) while lying still?
- ☐ (B) only when changing positions?
- ☐ (C) both?

2. In what position do you sleep? *(Check all that apply)*

- ☐ (A) right side
- ☐ (B) left side
- ☐ (C) stomach
- ☐ (D) back
- ☐ (E) chair/recliner
- ☐ (F) other: _____

3. Do you have pain/stiffness upon getting out of bed in the morning?

☐ (A) Yes ☐ (B) No

4. As the day progresses, do your symptoms: *(Check one)*

- ☐ (A) increase
- ☐ (B) decrease
- ☐ (C) not change?

5. What aggravates your symptoms? *(Check all that apply)*

- ☐ (A) sitting
- ☐ (B) going to/rising from sitting
- ☐ (C) standing
- ☐ (D) squatting
- ☐ (E) lying
- ☐ (F) sleeping
- ☐ (G) walking
- ☐ (H) up/down stairs
- ☐ (I) sustained bending
- ☐ (J) looking up overhead
- ☐ (K) reaching overhead
- ☐ (L) reaching out from body
- ☐ (M) reaching behind back
- ☐ (N) reaching across body
- ☐ (O) repetitive activities including _____
- ☐ (P) recreation/sports including _____
- ☐ (Q) household activities including _____
- ☐ (R) coughing/sneezing
- ☐ (S) taking a deep breath
- ☐ (T) talking
- ☐ (U) yawning
- ☐ (V) chewing
- ☐ (W) swallowing
- ☐ (X) stress
- ☐ (Y) other: _____

6. What relieves your symptoms? *(Check all that apply)*

- ☐ (A) sitting
- ☐ (B) rising from sitting
- ☐ (C) standing
- ☐ (D) lying
- ☐ (E) walking
- ☐ (F) stretching
- ☐ (G) exercise
- ☐ (H) recreation/sports including _____
- ☐ (I) rest
- ☐ (J) cold
- ☐ (K) heat
- ☐ (L) massage
- ☐ (M) traction
- ☐ (N) alcohol
- ☐ (O) whirlpool
- ☐ (P) medication
- ☐ (Q) nothing
- ☐ (R) other: _____

7. What previous treatment have you had? *(Check all that apply)*

- ☐ (A) none
- ☐ (B) medication (oral)
- ☐ (C) physical therapy
- ☐ (D) joint manipulation by a chiropractor or osteopath
- ☐ (E) massage therapy
- ☐ (F) exercise
- ☐ (G) bracing/taping
- ☐ (H) traction
- ☐ (I) injection into the spine
- ☐ (J) injection into the skin/muscles
- ☐ (K) surgery (on the body region of your current problem)
- ☐ (L) hypnosis
- ☐ (M) biofeedback
- ☐ (N) TENS unit
- ☐ (O) acupuncture _____
- ☐ (P) bed rest
- ☐ (Q) overnight hospitalization
- ☐ (R) Other _____

8. Have you had any of the following:

- ☐ (B) X-rays
- ☐ (C) CT Scan
- ☐ (D) MRI
- ☐ (E) Arthrogram
- ☐ (F) Stress X-ray Test (Telos)
- ☐ (G) Other: _____

Results? _____

9. I am aware that the information gathered from my course of physical therapy may be anonymously used for internal research or for publication by Therapeutic Associates, Inc. *(Please initial)* _____