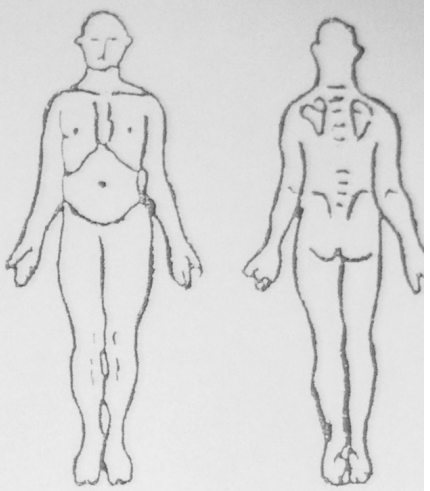
PATIENT QUESTIONNAIRE

SPECIAL MEDICAL SERVICES
FLOYD COUNTY MEDICAL CENTER
PHYSICAL & RESPIRATORY THERAPY



NAME _____
PHONE# _____

1. Please shade in the location of your symptoms.

2. Please describe relevant symptoms: (e.g. sharp, dull stabbing).

3. Please describe HOW and WHEN your problem developed.

4. Please rate your intensity of discomfort on a scale of 1 to 10.
   0 1 2 3 4 5 6 7 8 9 10

5. Is your pain constant, periodic, or occasional?

6. What positions or activities make your symptoms worse?
   What positions or activities make your symptoms better?

7. List significant current and past medical conditions: (e.g. heart disease, cancer, pregnancy, pacemaker, spinal implants).

8. List any goals you would like to achieve with Physical Therapy treatment.

9. Have you received any PHYSICAL THERAPY TREATMENTS in this calendar year? (JAN –DEC) Or have you received any other treatments for this condition? Please describe.

10. List medications you are currently taking for this problem.

11. List any special test, such as, X-rays, MRI, EMG, in regards to this problem.

12. Is this work related as a worker's compensation claim?

13. Do you need to pre-certify for physical therapy services under your health care plan?

14. Are treatments provided by Floyd County Medical Center covered by your insurance