CAMC Physical Therapy & Sports Medicine CENTER
Charleston Area Medical Center

New Patient Questionnaire Form

Date:_____ Occupation:_____ Are you currently working?_____

1. Please rate your pain from 0 to 10 for the condition that brings you to our facility today.
   "0" means "no pain", "10" means "Emergency Room" pain: _____
   (Please indicate the location of your pain on the diagram on the back of this form)

2. When did the problem start?_____

3. Was there an injury? Yes No

4. Have you had X-rays or other tests done? Yes No
   If yes, what were the results?_____

5. Have you had surgery for this condition? Yes No
   If yes, date and type of surgery:_____

6. Have you fallen in the last 2 months? Yes No

7. Please list current medical conditions/problems and any previous surgeries:_____
_____
_____

8. What medications are you currently taking?_____
_____
_____

9. Please list any allergies:_____

10. Please check the appropriate box concerning your ability to perform the following activities:

	Able	Difficult	Need Assistance	Unable
Getting in/out of a car	☐	☐	☐	☐
Getting up out of a chair	☐	☐	☐	☐
Sitting up from a lying position	☐	☐	☐	☐
Getting in/out of shower/tub	☐	☐	☐	☐
Shaving/brushing teeth	☐	☐	☐	☐
Grooming hair	☐	☐	☐	☐
Getting dressed	☐	☐	☐	☐

11. How did you hear about us?
   - ☐ MD Office
   - ☐ Print ad, billboard, radio
   - ☐ CAMC Website *(www.camc.org)*
   - ☐ Internet search engine (Google, Yahoo, etc)
   - ☐ Friend/Family Member
   - ☐ Other: _____

Because violence is so common in many people's lives and results in serious health problems, I ask all my patients about it:

12. Within the last year, have you been hit, slapped, kicked or otherwise physically hurt by someone?_____ If yes, would you be willing to talk about it?_____