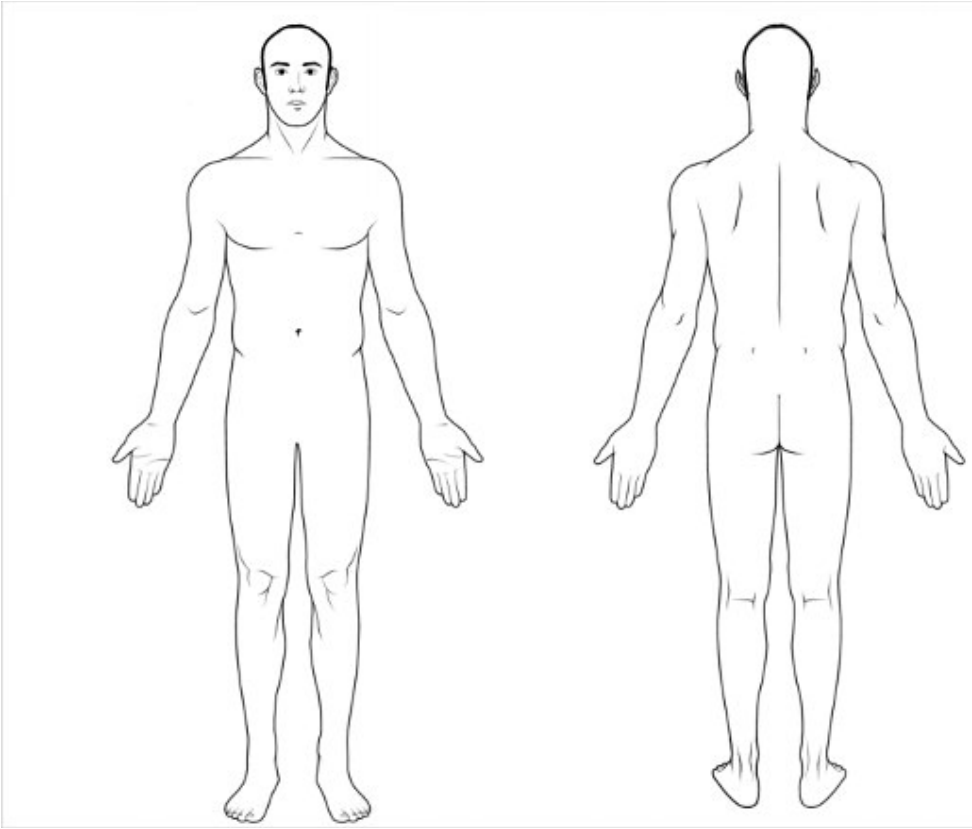
G4athlete

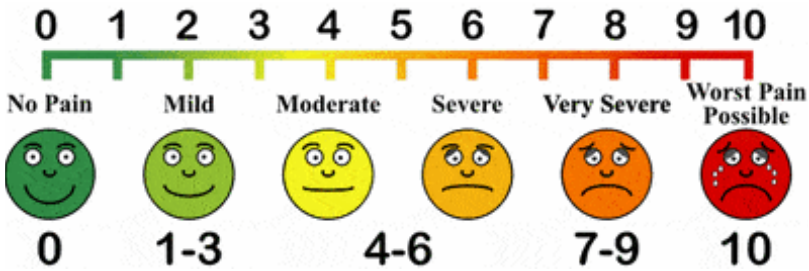
FUNCTION AND SYMPTOM QUESTIONNAIRE

NAME_____ **DATE** _____

Please indicate where you are experiencing pain or symptoms on the diagram below



Please circle the number which best describes your pain/symptoms



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Problem or Chief Complaint_____

Date of Injury OR Surgery _____

Mechanism of Injury_____

Primary reason for attending therapy_____

Circle the words that best describe your pain

Dull Ache	Burning	Heavy	Sore	Deep Ache	Throbbing
Twinge	Stabbing	Squeezing	Cramp	Nagging	Sharp
Radiating	Unrelenting	Drawing	Numbness	Tingling	Other

Are your symptoms Worsening Improving Remaining the same

What eases the pain?_____

What aggravates the pain?_____

Functional limitations due to this injury/condition?_____

_____

Please describe any previous treatment for this problem (physical therapy, chiropractic, massage, acupuncture, other)?

_____

_____

_____

Which meals do your eat regularly, check all that apply?

Breakfast Lunch Dinner Snacks (Times_____)

How much water do you drink per day?

0-25 oz 25-50 oz 50-75 oz 75-100 oz 100 + oz

How would you rate your overall nutrition?

Excellent Good Fair Poor

On average, how would you rate your daily energy?

Excellent Good Fair Poor

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PRIMARY Sport or Activity_____

SECONDARY Sport/Cross-Training Activities

_____

_____

ATHLETIC HISTORY - Please list past sports/activities and years of participation

_____

_____

_____

_____

How many days per week do you engage in physical activity

None 1 2 3 4 5 6 7

Current Stress Level

1 2 3 4 5 6 7 8 9 10

Please describe the three most important things you would like to achieve through physical therapy (in order of importance)

1. _____

2. _____

3. _____

Referring Physician_____

Date of last visit_____ **Date of next visit**_____

How did you hear about G4 Athlete?_____