OLYMPIC PENINSULA PHYSICAL THERAPY

POST-OPERATIVE QUESTIONNAIRE

NAME: _____

DATE: _____

DATE OF BIRTH: _____

This form contains a series of questions designed to help your Physical/Occupational 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. Date of Surgery: _____ Date of Injury: _____
   Type of Surgical Procedure (if known): _____

2. Which of the following best describes how your injury occurred? *(Check one)*
   □ Lifting □ MVA (car accident) □ A fall □ During recreation/sports
   □ Trauma □ Cumulative Trauma/Overuse_____
   □ Degenerative process □ Other: _____ □ Unknown

3. What symptoms are you experiencing since your surgery? _____
   _____

4. Nature of the Symptoms (Check all that apply) □ sharp □ aching
   □ Tingling □ Dull □ Occasional □ Numbness
   □ Throbbing □ Constant □ Other: _____

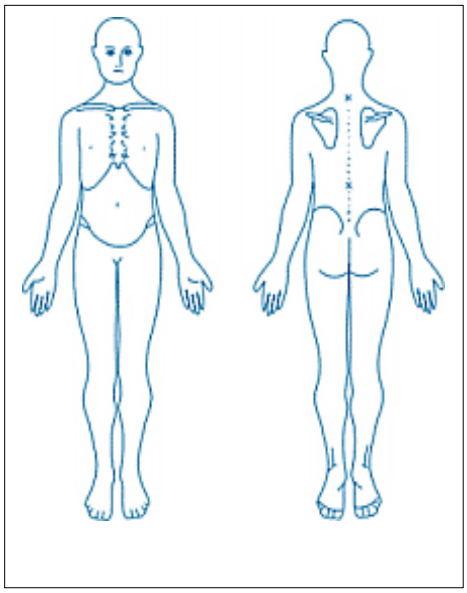
5. Please indicate your pain level on a scale of 0 to 10_____
   (0 = no pain, 1,2,3 = low pain, 4,5,6 = moderate pain,
   7,8,9 = intense pain, 10 = emergency)

6. Does the pain wake you at night?
   □ No □ Yes Frequency? _____ If "yes", is it present
   □ While lying still? □ Only when changing positions? □ Both?

7. Are your symptoms worse in the: □ Morning □ Evening □ Neither

8. Have you had any falls in the past year?
   (circle) 0 1 2 3 4 >4

   Have you sustained any injury after the fall(s)?
   (circle) Yes No N/A



9. What aggravates your symptoms? *(Check all that apply)*
   □ Sitting _____
   □ Going to/rising from sitting
   □ Standing _____
   □ Kneeling/squatting _____
   □ Lying _____
   □ Driving
   □ Lifting _____
   □ Repetitive activities including (gripping, typing, reaching, etc) _____
   □ Getting dressed _____
   □ Reaching overhead
   □ Reaching out from body
   □ Reaching behind back
   □ Reaching across body
   □ Sustained bending
   □ Walking _____
   □ Stairs
   □ Coughing/sneezing
   □ Taking a deep breath
   □ Sleeping
   □ Looking up overhead
   □ Swallowing
   □ Recreation/sports including _____
   □ Household activities including _____
   □ Other: _____

PLEASE COMPLETE OTHER SIDE

10. What relieves your symptoms? *(Check all that apply)*
□ Sitting □ Changing positions □ Standing □ Lying □ Walking □ Stretching
□ Exercise □ Rest □ Cold □ Heat □ Massage □ Splinting/brace wear
□ Traction □ Whirlpool □ Medication □ Alcohol □ Nothing □ Other: _____

11. What previous treatment have you had related to your injury? *(Check all that apply)*
□ None □ Bracing/Taping □ TENS unit □ Medication (oral)
□ Traction □ Massage therapy □ Physical/Occupational therapy □ Injection into the spine
□ IME □ Chiropractic/Osteopathic □ Injection into the skin/muscles

12. If surgery was performed on your leg, please indicate weight bearing status:
□ Non-weight bearing □ Partial weight bearing □ Weight bearing as tolerated

13. Please indicate any assisted device/brace you have used or are still using following your surgery:
□ Walker □ Crutches □ Brace □ Cast □ Sling □ None

14. Please list any exercises that your doctor or a therapist has instructed you to perform following your surgery:
_____

15. Do you exercise on a regular basis? □ Yes □ No _____

16. Do you have access to exercise equipment/pool facilities? □ Yes □ No _____

17. Please list any activities that you can't do now as a result of injury/symptoms: _____
_____

18. What goals would you like to achieve from therapy? _____

19. What is your… Height _____ Weight _____ Blood Pressure _____ Heart Rate _____

20. Do you smoke? □ Yes □ No If yes, how much? _____

21. ***Please indicate if you have had or currently have the following medical conditions:*** □ UNREMARKABLE
□ Cancer □ Heart Disease □ Pacemaker □ HIV Positive
□ High Blood Pressure □ Diabetes □ Pregnant (currently) □ Hepatitis C
□ Arthritis □ Bowel/Bladder problems □ History of Seizures □ Bone/Joint Disorder/Injury
□ Joint Replacement □ Breathing difficulties □ Fractures □ Drug Allergies

22. **WORK HISTORY:** Are you currently working? □ Yes, normal duty □ Yes, restricted duty □ No □ Retired
Occupation (be specific): _____ Normal work schedule: _____
Briefly describe your work duties: _____

If you were injured on the job or work is affected by your current symptoms, please fill out questions 23-26

23. Last day of full duty? _____ Is light duty available? □ Yes □ No

24. What positions are you in while working? (check all that apply)
Indicate frequency: *S=Seldom, O=Occasional, F=Frequent*
□ Sitting _____ □ Standing _____ □ Walking _____ □ Bending _____ □ Push/Pull _____
□ Kneeling/Squatting _____ □ Forward Reaching _____ □ Overhead Reaching _____
□ Repetitive grasp/pinch _____ □ Climbing (ladders/stairs, etc) _____

25. Max weight carried (lbs): _____ Distance: _____
Max weight lifted from floor: _____ From knee to shoulder height: _____ Overhead: _____

26. Return to work goal: Job of Injury: □ Yes □ No □ Other _____

Therapist Signature: _____ Date: _____