# Osprey Physical Therapy & Sports Medicine

Soaring Together In Your Health and Wellness

## Pain/Injury Questionnaire

(What brings you in?)

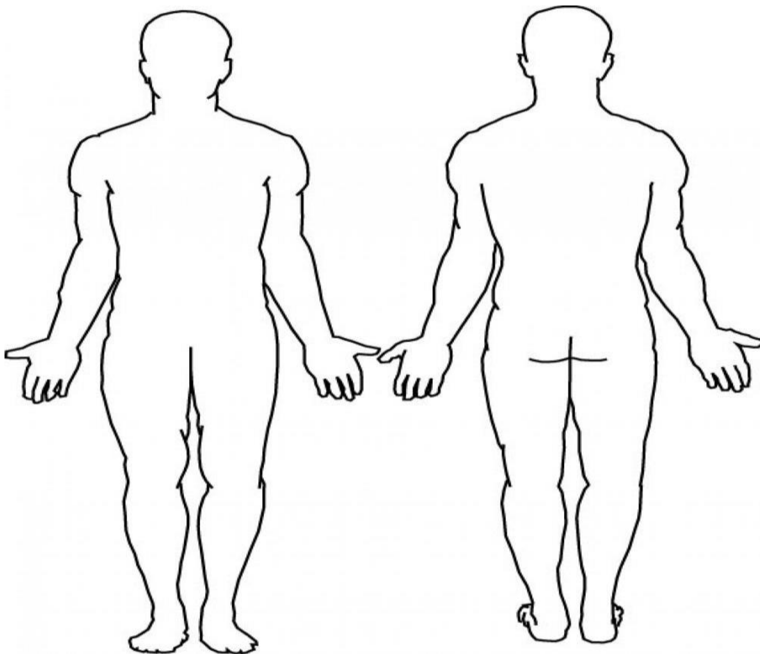
1. What pain(s)/problem(s) are you hoping to resolve with physical therapy?

2. Have you had physical therapy for anything in the past?

3. What have you heard about physical therapy?

4. Do you have any concerns about physical therapy? If so, what are they?

5. Where is your pain? Please mark on the drawing below where you feel your pain.



6. Is your pain:

   Constant______

   Intermittent______

7. Please describe your symptoms by selecting all that apply:

   Ache_____Throb_____Burn_____Stab_____Sharp_____Numb_____Shooting_____Dull_____

8. On the scale below, please mark the severity of your pain RIGHT NOW:

   0 (no pain)____ 1____ 2____ 3____ 4____ 5____ 6____ 7____ 8____ 9____ 10 (max pain)____

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