

Confidential General Health & Persistent Pain Screening Questionnaire

Name: _____

Date: _____

Please *briefly* write in your own words the primary reason for your Physiotherapy consult: (e.g. back & leg pain)

.....

Are you currently taking any medication? Simply check “✓” (Yes) (No) (Please list).....

.....

FOR WOMEN: Are you currently pregnant or think you might be pregnant? (Yes) (No)

Do you currently have or have a history of any medical condition(s)? (Please check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Broken bones/fractures | <input type="checkbox"/> Heart disease |
| <input type="checkbox"/> Recent infection (chest, urinary tract, etc.) | <input type="checkbox"/> Hypertension / High cholesterol |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Allergies..... | <input type="checkbox"/> Respiratory / lung problems |
| <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Skin diseases | <input type="checkbox"/> Other..... |

Any surgeries:

Within the past year, have you had any of the following symptoms? (Please check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Chest pain / Heart palpitations | <input type="checkbox"/> Vomiting / Nausea |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Difficulty swallowing |
| <input type="checkbox"/> Dizziness / blackouts | <input type="checkbox"/> Urinary problems / Bowel problems |
| <input type="checkbox"/> Loss of balance / coordination | <input type="checkbox"/> Fever / chills / sweats |
| <input type="checkbox"/> Weakness in arms and legs | <input type="checkbox"/> Weight gain |

General Health

Have you recently had any unexplained weight loss? Loss of appetite? Night sweats?

(Yes) (No)

Do you have unrelenting/constant night pain?

(Yes) (No)

Do you have a history of oral steroid use? (e.g. cortisone, prednisone)

(Yes) (No)

During the past month, have you often been bothered by feeling down, depressed, or hopeless?

(Yes) (No)

During the past month, have you often been bothered by little interest or pleasure in doing things?

(Yes) (No)

Please tell us what your 3 *primary goals* are or what you wish to achieve with your Physiotherapy treatments:

(e.g. return to playing tennis 3X/week, return to my full-time work as a ..., be able to walk for 30 minutes, eliminate headaches)

Fear & Concern

Do you fear and avoid many physical activities as they may harm your condition or worsen your pain?

(Yes) (No)

Do you feel that there is something dangerously wrong with your body?

(Yes) (No)

Do you feel that people aren't taking your condition seriously enough?

(Yes) (No)

Do you frequently worry about whether the pain will end?

(Yes) (No)

Stress & Hope

Do you feel that you currently have significant stress in your life?

Not stressed at all 0 1 2 3 4 5 6 7 8 9 10 Extremely stressed

How would you rate your current level of anger in your life?

Not angry at all 0 1 2 3 4 5 6 7 8 9 10 Extremely angry

In the past month, have you participated in any type of sports or hobbies that you normally enjoy?

(Yes) (No)

In the past month, have you done any 'fun' activities such as walking in the park, going to a movie or a meal with friends, taking a vacation, etc?

(Yes) (No)

What is your level of hopefulness that you will improve and return to your regular activities in the next 3 months?

Not hopeful at all 0 1 2 3 4 5 6 7 8 9 10 Very hopeful

Work, Hobbies & Exercise

How would you rate your current level of job satisfaction?

I hate my job 0 1 2 3 4 5 6 7 8 9 10 I absolutely love my job

Do you generally like / get along with your co-workers / your employer / boss?

I hate my job 0 1 2 3 4 5 6 7 8 9 10 I absolutely love my job

Are you **currently** involved in heavy labor work, sport, or exercise program that may be contributing your pain?

(Yes) (No)

Do you have a regular exercise program that increases you heart rate?

(Yes) (No)

Do you feel that you are generally physically fit?

(Yes) (No)

Water & Hydration

Do you drink LESS THAN 3 glasses of healthy liquids? (i.e. water, decaffeinated herbal tea, juice) each day?
(Note: Alcoholic drinks do not count, as they are diuretics!)

(Yes) (No)

Have you noticed if your urine is dark yellow in colour or has a strong odour?

(Yes) (No)

Nutrition & Digestion

Do you smoke?

(Yes) (No)

Do you frequently eat at fast food restaurants (e.g. 1-2 times per day on most days)?

(Yes) (No)

Do you eat at least 2 servings of **fresh** fruits & 2 servings of **fresh** vegetables per day?

(Yes) (No)

Do you have any stomach issues such as bloating or abdominal cramps? (Eg. Irritable Bowel Syndrome)

(Yes) (No)

Sleep

Do you have daytime sleepiness?

(Yes) (No)

Do you know or have been told that you snore excessively during sleep?

(Yes) (No)

Does your sleeping partner snore?

(Yes) (No)

Do you get less than 6 hours of sleep regularly?

(Yes) (No)

Do you have pain or something else that frequently awakens you from sleep?

(Yes) (No)

Breathing

Do you ever feel short of breath while simply resting?

(Yes) (No)

Do you ever find yourself gasping for air or as if you are catching your breath?

(Yes) (No)

Do you often sigh?

(Yes) (No)