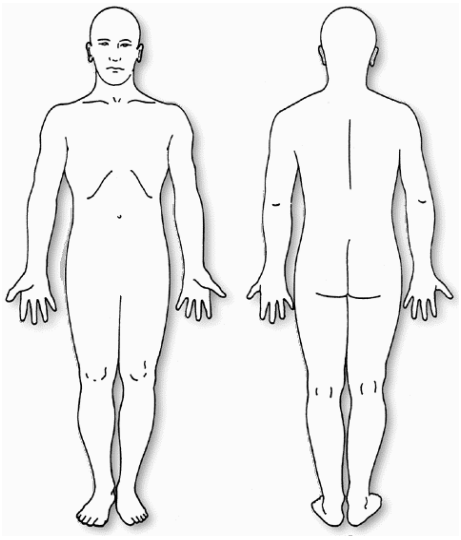
KEEP MOVING FORWARD
MOMENTUM
PHYSICAL THERAPY AND WELLNESS

727.804.3481
MomentumPTWellness@gmail.com
www.MomentumPhysicalTherapyWellness.com

Re-evaluation Questionnaire

Please help us serve you better by taking a few minutes to provide the following information.

Patient name:		**Date:**	
DOB:			

What is the primary issue/problem that you are experiencing today?	**Please shade in areas where you have pain, discomfort, or tension.**
	
Secondary concern/problem?	
As a result, I am now having difficulty with:	
Are you currently experiencing pain as a result of these symptoms? If yes, what is it like?	
What changes have you experienced or noticed since beginning physical therapy?	
At what time of day are your symptoms the worst?	
At what time of day are your symptoms the best?	
What activities increase your pain?	
What activities decrease your pain?	

Please rate your pain in the last 24-72 hours **Using the "0 -10" scale where 0 is no pain and 10 is the worst possible pain.**	At its worst	
	At its best	
	At present	
	Night (sleeping)	

Do you engage in regular exercise?			**Yes**		**No**
What type and how often?					
Are you able to exercise now?			**Yes**		**No**
Do you have discomfort, shortness of breath, or pain with exercise?			**Yes**		**No**
Please Describe:					
In general, your lifestyle is:	**1**	**2**	**3**	**4**	**5**
	Active		**Average**		**Inactive**

KEEP MOVING FORWARD
MOMENTUM
PHYSICAL THERAPY AND WELLNESS

727.804.3481
MomentumPTWellness@gmail.com
www.MomentumPhysicalTherapyWellness.com

Re-evaluation Questionnaire

If sleep is a problem, answer these questions:

Do you have trouble falling asleep?	Yes	No
Is your sleep restful?	Yes	No
Do you find it difficult to lie down?	Yes	No
Do you find it difficult to change positions in bed?		
How many times do you wake in the night?		
How long before you fall back to sleep?		

If any daily activities are limited, answer this question.

*List all the **Tasks / Activities** that you have difficulty performing and your tolerance (minutes/hours).*

If you are no longer able to perform an activity, your tolerance would be "0".

Task / Activity	Tolerance (minutes/hours)

I walk for		**minutes before needing to rest**
I stand for		**minutes before needing to sit**
I sit for		**minutes before needing to change positions/get up**

Do you have trouble getting up from a chair?	Yes	No
Do you have trouble putting on your shoes and socks?	Yes	No
Do you have difficulty climbing stairs?	Yes	No

Patient Goals

Please list the activities that you would like to be able to do as a result of therapy.

Task / Activity	Duration / How Often	By When
Other Goals?		