Physical Activity Questionnaire

LONE PEAK PHYSICAL THERAPY

Patient Name:_____ Date: _____

Physical Activity

Have you been cleared by your provider to begin physical activity? ☐ Yes ☐ No ☐ NA

Current level of activity (i.e., how often are you exercising, and in what ways):

_____

_____

Goal(s) for returning to exercise: _____

_____

_____

_____

How realistic do you feel it is to accomplish your goal(s) listed above on a scale from 1-10 (1=Might need modification, 10=Definitely achievable): _____

How comfortable are you with physical touch? (i.e, touching to correct movement, diastasis recti checks):

_____

Stress

Rate your stress on a scale from 1-10 (1=Little, 10=Extreme) _____

Do you feel depressed or anxious, or do you suffer from mood swings? ☐ Yes ☐ No

Have you ever been diagnosed with postpartum depression or anxiety? ☐ Yes ☐ No

Sleep

How much sleep do you get in a 24-hour period? _____

Hydration

How much water do you drink? _____

Pain

Do you have pain with…

Back, leg, groin, abdominal pain? ☐ Yes ☐ No ☐ NA

Knee(s)? ☐ Yes ☐ No ☐ NA

Any other joint (i.e. wrist, neck)? ☐ Yes ☐ No ☐ NA

If yes to any above, please explain:

_____

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Medical History

Has a doctor ever prescribed medication for high blood pressure, or diagnosed you with a heart condition?

☐ Yes ☐ No

Do you feel pain in your chest at rest, during activities or exercise? ☐ Yes ☐ No

Has a doctor ever diagnosed you with a chronic medical condition? ☐ Yes ☐ No

If yes, please explain:_____

Are you currently taking medication for a chronic medical condition? ☐ Yes ☐ No ☐ NA

Do you ever lose balance due to dizziness or have you lost consciousness in the past 12 months?

☐ Yes ☐ No

Pelvic Symptoms

Are you experiencing heaviness, dragging or bulging in the pelvic area? ☐ Yes ☐ No

Do you experience heaviness, dragging or bulging when performing exercises? ☐ Yes ☐ No

If yes, please explain: _____

Have you been diagnosed with a pelvic prolapse? ☐ Yes ☐ No

Have you had a hysterectomy? ☐ Yes ☐ No

Have you experienced difficultly controlling air from exiting your vagina? ☐ Yes ☐ No

At Lone Peak Physical Therapy, we create an open, honest and accepting environment. We ask the same of our patients/clients to communicate with us in how they are feeling and handling the work load we provide. By signing below we are holding ourselves to the highest level of care and in return ask for you to do the same. Additionally, I have answered all questions honestly and to the best of my knowledge.

Signature:_____ Date:_____

Thank you for taking the time to fill out this questionnaire.