STARS

Sports Therapy and Rehabilitation Services
Non-Surgical Questionnaire

PLEASE ANSWER THESE QUESTIONS IF YOU ARE HERE DUE TO AN INJURY OR CONDITION.

Name: _____ Date: _____

Date of injury/condition onset: ____/____/____
Describe your current symptoms: _____
_____
Did your symptoms begin as a result of a specific injury, gradual onset, or disease? _____
Explain: _____
When did you first notice these symptoms? (Use specific day if trauma/accident)_____
Have you had previous therapy for this injury/condition? ☐Yes ☐No
If yes, please give dates, length of therapy, and setting in which treatment took place:
Hospital _____
Outpatient Clinic _____
Home Health _____
Has your work status changed because of this condition? ☐ Yes ☐ No
What goals would you like to accomplish through therapy? _____

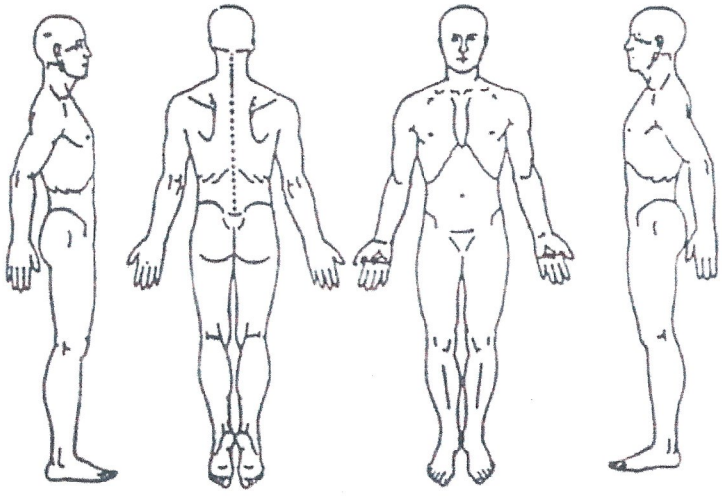
How often are symptoms experienced?
☐Constantly (76-100% of day) ☐Frequently (51-75% of day)
☐Occasionally (26-50% of day) ☐Intermittently (0-25% of day)

How much have your symptoms interfered with your work, hobbies, or daily activities?
☐Not at all ☐Quite a bit ☐A little bit ☐Moderately ☐Extremely

Does your condition affect your sleep? ☐ Yes ☐ No

Are your symptoms changing? ☐ Improving ☐ No Change ☐ Worse

What activities make your pain worse? _____
What can you do to make your pain better?_____
Please indicate location and intensity of pain on figures:



Right Back Front Left

Please indicate your pain level today based on the pain scale below:

No Pain Unbearable
0 1 2 3 4 5 6 7 8 9 10

Pain level with medication: _____ Pain level without medication: _____
Pain level during activity: _____ Pain level while at rest: _____