

Oncology Rehabilitation Specialists, Inc.
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(425) 467-7105

Initial Questionnaire

Name: _____ Age: _____

Referring Physician: _____

Please describe your current symptoms:

When did these symptoms begin? _____

Have you had any surgery? Yes _____ No _____

If yes, please describe the surgical procedure(s) and the dates they occurred:

Are your symptoms better or worse since they began? _____

What position or activity makes your symptoms worse?

What position or activity makes your symptoms better?

Have you had these symptoms before? Yes _____ No _____

If yes, when? _____

Are there any activities that you have difficulty doing now because of your symptoms?

If so, please list them: _____

If you are experiencing pain, please rank your pain on a scale from 0 to 10, 0 being no pain at all and 10 being the worst pain imaginable: _____

Are you currently taking any chemotherapy treatments? Yes _____ No _____

If yes, what drugs are you using? _____

Are you currently, or will you be doing radiation therapy? Yes _____ No _____

If yes, please indicate your start date: _____

Over →

Please list any medications you are currently taking:

Previous Medical History

Have you or anyone in your family ever been diagnosed with any of the following:

Condition	You Personally Yes/No	Family Member Yes/No	Which Family Member
Cancer	Y N	Y N	
If yes, what type:			
Asthma	Y N	Y N	
Diabetes	Y N	Y N	
Heart Problems	Y N	Y N	
High Blood Pressure	Y N	Y N	
High Cholesterol	Y N	Y N	
Blood Clots	Y N	Y N	
Pulmonary Edema	Y N	Y N	
Skin, tissue or Organ Infection	Y N	Y N	
Severe Headaches	Y N	Y N	
Osteoporosis	Y N	Y N	
Osteopenia	Y N	Y N	
Osteoarthritis	Y N	Y N	
Rheumatoid Arthritis	Y N	Y N	
Seizures	Y N	Y N	
Fibromyalgia	Y N	Y N	
Chronic Fatigue Syndrome	Y N	Y N	
Venous problems	Y N	Y N	
Other (please describe):			

Is there anything else you would like your physical therapist to know?
