# HANDS-ON Physical Therapy Reevaluation Questionnaire

(to be completed every 4-6 weeks)

What changes have you noticed over the past 4-6 weeks? _____

_____

_____

_____

What can you do now that you couldn't do before starting physical therapy? _____

_____

_____

_____

How often are your symptoms present? (Please circle or check one)
1. Constantly (76-100% of the day)
2. Frequently (51-75%)
3. Occasionally (26-59=0% of the day)
4. Intermittently (0-25%)

Has your tolerance to these activities improved with physical therapy? If so how?

| **Activity** | **Any time limits? How improved?** |
|---|---|
| Sitting | |
| Standing | |
| Walking | |
| Lifting | |
| Computer use | |
| Driving | |
| Sleep | |
| Recreation (list): | |

Are you doing your home exercise program and self-care activities on a regular basis? Yes or No
If yes, is it controlling your symptoms?_____
If no, why not?_____

What is the most painful area of your body? _____
Usual pain level during a normal day ( scale of 1 to 9)? _____
Lowest pain level in the past week? _____
Highest pain level in the past week? _____
Was there an aggravating activity associated with the high pain level? _____
The % of improvement since you started physical therapy. _____

What is the second most painful area of your body? _____
Usual pain level during a normal day ( scale of 1 to 9)? _____
Lowest pain level in the past week? _____
Highest pain level in the past week? _____
Was there an aggravating activity associated with the high pain level? _____
The % of improvement since you started physical therapy. _____

Do you feel you need to continue physical therapy? Yes or No
If yes, what gains and functional goals do you hope to achieve if you continue? _____

_____

_____

_____

**Patient name:** _____ **Date:** _____