PHYSICAL THERAPY FOR WOMEN
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Locations:
Fort Worth
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FIBROMYALGIA QUESTIONNAIRE

Name __________________________________ Date________ Date of Birth ___________

When did you receive your current diagnosis? ____
Please describe your main problem: ____
When did it begin? ____; was there a specific event that seemed to trigger the onset of your symptoms? ❑ Yes ❑ No If yes, what was the event __________________
____; If no, describe how your symptoms began and progressed
____; is it getting: better, worse, or staying the same (circle one)
Please describe activities or things that you cannot do because of your problem ________________________
____

SOCIAL HISTORY:
Marital Status ___________________________________ Ages of children living at home?_______________
Education level _________________________________
What are your hobbies? ____

Attitude Towards Problem
- ❑ No problem
- ❑ Minor inconvenience
- ❑ Slight problem
- ❑ Moderate problem
- ❑ Major problem

Confidence in Controlling Your Problem
- ❑ Complete confidence
- ❑ Moderate confidence
- ❑ Little confidence
- ❑ No confidence

DIET:
Are you currently on a special diet? ❑ Yes ❑ No If yes, please describe _____________________________
____
Daily Fluid Intake: (*enter number of 8 oz cups/glasses of fluid taken daily*)
- ❑ Water ___
- ❑ Caffeinated drinks (coffee, tea, colas, chocolate) ___
- ❑ Decaffeinated drinks (coffee, tea, colas) ___
- ❑ Alcohol ___
- ❑ Juices ___
- ❑ Other ___

Do you restrict fluids because of your incontinence? ❑ Yes ❑ No

FUNCTIONAL LIMITATIONS: (*check yes or no*)
Do you have difficulty:

Getting on/off the toilet? ❑ Yes ❑ No
Getting clothes on/off? ❑ Yes ❑ No
With toilet hygiene? ❑ Yes ❑ No
Getting out of bed? ❑ Yes ❑ No

List strategies you use to control your symptoms: ____
____
____

What goals do you hope to achieve in this program? ____
____
____