



PATIENT INTAKE QUESTIONNAIRE FORM

Thank you for taking the time to complete this questionnaire. The information you give is very important to us and is helpful in providing you with the best possible care. **PLEASE FILL IN ALL THE BLANKS.**

PATIENT INFORMATION:

DATE OF BIRTH ____/____/____ DATE OF INJURY ____/____/____ **TODAY'S DATE** ____/____/____

PATIENT FULL NAME _____ SSN ____-____-____

ADDRESS _____ CITY _____ ZIP _____

HOME PHONE () _____-_____ **CELL PHONE** () _____-_____

WOULD YOU LIKE TO RECEIVE OUR MONTHLY ELECTRONIC HEALTH NEWSLETTER? YES NO

E-MAIL ADDRESS _____

SPOUSE/PARENT/PARTNER NAME _____

SPOUSE/PARENT/PARTNER EMPLOYER _____ WORK PHONE _____

NEAREST RELATIVE NOT LIVING WITH YOU _____ HOME PHONE _____

PERSON TO CONTACT IN CASE OF EMERGENCY _____ HOME PHONE _____

WORK PHONE _____ CELL PHONE _____

DO YOU HAVE AN ATTORNEY? NO YES NAME _____ PHONE _____

Due to various insurance benefit limitations it is important to list how many **previous visits** you've attended **this year** of:

Speech therapy _____ Physical Therapy _____ Chiropractor _____

EMPLOYER INFORMATION:

YOUR EMPLOYER _____ WORK PHONE _____ EMP ID# _____

ADDRESS _____ CITY _____ ZIP _____

OCCUPATION _____ CURRENTLY WORKING? NO YES

ANY RESTRICTIONS? NO YES IF YES, WHAT ARE THEY _____

HOW LONG AT JOB? _____ DESCRIBE YOUR JOB DUTIES _____

LIFTING: YES NO HOURS _____ **STAND:** YES NO HOURS _____ **SIT:** YES NO HOURS _____

WALK: YES NO HOURS _____ HOURS WORKED IN A SHIFT _____ SHIFTS WORKED IN A WEEK _____

TOTAL HOURS WORKED IN A WEEK _____

PREVIOUS OCCUPATION _____ LENGTH OF EMPLOYMENT _____

PHYSICIAN INFORMATION:

FAMILY PHYSICIAN _____ PHONE _____

REFERRING PHYSICIAN _____ PHONE _____

CARDIOLOGIST _____ PHONE _____

1. Dominant Hand? Right Left

2. Do you smoke? No Yes If yes, how many packs/day? _____

3. Do you drink alcohol? No Yes If yes, approximately how many drinks per week? _____

4. Please check any **FAMILY** history of:

- | | | |
|--|--|---|
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Rheumatoid arthritis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Gout | <input type="checkbox"/> Sickle Cell Anemia |
| <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> NONE OF THE ABOVE |
| <input type="checkbox"/> Thyroid disease | | |

5. Please check and **PERSONAL** history of:

- | | | | |
|--------------------------------------|---|--|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart condition | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Metal implants | <input type="checkbox"/> Seizures | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Current pregnancy |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Osteoporosis |

6. Please check any of the following which you have had in the **PAST YEAR:**

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Weight gain | <input type="checkbox"/> Weakness | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Weight loss | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Spontaneous night fever | <input type="checkbox"/> Mental lethargy |
| <input type="checkbox"/> Appetite change | <input type="checkbox"/> Night sweats | <input type="checkbox"/> Urinary tract infection | <input type="checkbox"/> Hospitalization |
| <input type="checkbox"/> Palpitations | <input type="checkbox"/> Night pain | <input type="checkbox"/> Physical fatigue | <input type="checkbox"/> Restless disturbed sleep |
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Atherosclerosis | <input type="checkbox"/> Total Cholesterol great then 240 mg/dl |
| <input type="checkbox"/> Gall bladder disease | <input type="checkbox"/> Intestinal Problems | <input type="checkbox"/> Hernia or any condition that may be aggravated by lifting | |

Woman Only

- | | | |
|-----------------------------------|------------------------------------|---|
| <input type="checkbox"/> Pregnant | <input type="checkbox"/> Lactating | <input type="checkbox"/> Anticipating pregnancy |
|-----------------------------------|------------------------------------|---|

7. Please check any of following specific tests that have been performed for your PRESENT condition:

- | | | | |
|--------------------------------------|-----------------------------------|---|--|
| <input type="checkbox"/> X-rays | <input type="checkbox"/> CAT scan | <input type="checkbox"/> Halter monitor | <input type="checkbox"/> Electrocardiogram |
| <input type="checkbox"/> MRI | <input type="checkbox"/> EMG | <input type="checkbox"/> Nerve conduction | <input type="checkbox"/> Stress test |
| <input type="checkbox"/> Other _____ | | | |

8. Please list **all current medications:** (Include over-the-counter pain killers, **Vitamins, Oxygen**, antacids etc...) _____

9. Please list **all surgeries** with approximate dates: _____

10. Please explain **how** your injury happened: _____

11. Date of your injury or date when you first noticed symptoms: ____/____/____
12. **Where** did your injury or accident occur? At Work Motor Vehicle Accident Other _____

13. Since the initial onset, my symptoms are (check one): Improving Getting Worse Same

14. Please describe your symptoms, including **intensity** and **frequency**: _____

15. Dates of work missed due to injury?
 None From _____ to _____

Were you hospitalized for this injury/condition? No Yes If yes, from _____ to _____

16. Pre-injury hours worked per week _____ Current hours worked per week _____

17. Have you had any similar past injuries or ailments? No Yes Please explain: _____

18. What activities make your symptoms worse or are difficult to perform. Be as specific as you can for both **HOME** and **WORK**. _____

19. What are your hobbies? _____

20. If you are having **headaches**, please describe:

Location: _____

Frequency: (constant, daily, etc...) _____

Average intensity: (circle)

Mild Severe
0 1 2 3 4 5 6 7 8 9 10

21. How many minutes can you do the following **without increased symptoms**? Sit _____ Stand _____ Walk _____

22. Please describe any treatments you have received for your present condition: Include any therapy here or elsewhere; please be specific and include dates. _____

23. Describe what, if anything, helps to relieve your symptoms, (treatments, positions, medications)? _____

24. Please rate the following by using the scale below:

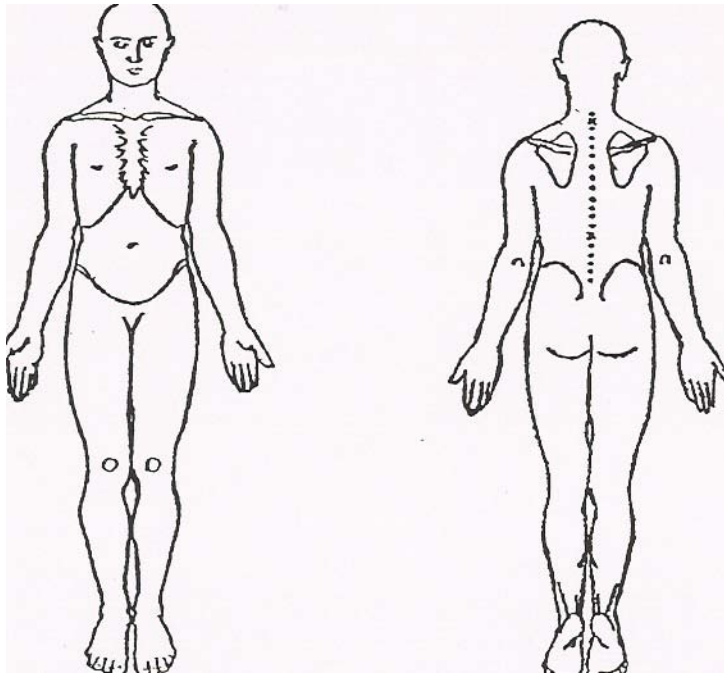
	Mild										Severe
Present stress level	0	1	2	3	4	5	6	7	8	9	10
Pain-At its worst	0	1	2	3	4	5	6	7	8	9	10
Pain-At its best	0	1	2	3	4	5	6	7	8	9	10
Pain- Most of the time	0	1	2	3	4	5	6	7	8	9	10
Pain- Right now	0	1	2	3	4	5	6	7	8	9	10

25. In the past year please check any event that has happened to you.

- | | | |
|--|---|---|
| <input type="checkbox"/> Change in residence | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Gain a new family member |
| <input type="checkbox"/> Death of spouse | <input type="checkbox"/> Divorce | <input type="checkbox"/> Marriage |
| <input type="checkbox"/> Retirement | <input type="checkbox"/> Death of a close family member | <input type="checkbox"/> Changing new school |
| <input type="checkbox"/> Sexual difficulties | <input type="checkbox"/> Major change in responsibility at work | <input type="checkbox"/> Vacation |
| <input type="checkbox"/> Major change in financial state | <input type="checkbox"/> Changing line of work | <input type="checkbox"/> Outstanding personal achievement |

26. Using the body diagram below, please indicate the location of any of the sensations listed. Mark the areas on the drawings with the symbol that best describes the sensation that you feel.

+++ Sharp pain ---- Numbness /// Dull pain ooo Pins and Needles xxx Burning pain



27. MY GOALS OF PHYSICAL THERAPY INCLUDE: (PLEASE BE SPECIFIC)

a.) Return to the following activities (include home, work and recreation):

<hr/>	<hr/>
<hr/>	<hr/>

b.) Additional goals:

<hr/>	<hr/>
<hr/>	<hr/>

EXTHD:FO:JH:4pg patient questionnaire:05/22/09

THANK YOU ONCE AGAIN FOR PROVIDING US WITH THE ABOVE INFORMATION!