

Patient Intake Questionnaire

Name _____ Date _____

DOB _____ Age: _____ Gender: M F

Referring MD _____ Primary MD (If different) _____

How did you hear about our clinic? (Doctor, other patient, advertising...) _____

Occupation? _____ Are you currently working? Yes No

If you are **NOT** working, what was your **last day of work**? _____

Date of injury/accident/onset of symptoms: _____ Date of surgery: _____

Briefly describe the problem you are here for and how it started: _____

Symptoms appeared: Gradually Suddenly

Feelings of: Pain Swelling Weakness Numbness If pain: Local (or radiates into) Arm Leg

Describe your pain: Aching Burning Dull Sharp Other: _____

Where is it located? _____

Similar problem on other occasions? Yes No Most recent was, when? _____

Does the pain wake you at night? Yes No If yes, can you get back to sleep? Yes No

What, if anything, can you do to make your symptoms **DECREASE**? _____

What, if anything, makes your symptoms **WORSE**? _____

Have you had any of the following **TESTS** for **THIS** problem? MRI Ultrasound CT Scan X-Ray

Bone Scan Arthrogram Other: _____

What, if known, are the results of the above tests? _____

Please list any surgeries, injuries for which you have been treated, or other conditions for which you have been hospitalized:

INJURY	SURGERY	HOSPITALIZATION	REASON	DATE
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

If surgery; recovery has been: Full Partial Not at all

(Continued on back)

Indicate which of the following conditions **YOU** (or ANYONE IN YOUR IMMEDIATE FAMILY) have **EVER** been diagnosed as having or have at the present:

YOU	FAMILY MEMBER		YOU	FAMILY MEMBER	
<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Gastritis/ulcers
<input type="checkbox"/>	<input type="checkbox"/>	Asthma/Emphysema/Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Heart (surgery, attack, disease)
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis: Osteo, Rheumatoid	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure
<input type="checkbox"/>	<input type="checkbox"/>	AIDS/HIV positive	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis: A B C D
<input type="checkbox"/>	<input type="checkbox"/>	Artificial joints (hip, knee, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia
<input type="checkbox"/>	<input type="checkbox"/>	Anxiety attacks	<input type="checkbox"/>	<input type="checkbox"/>	Hysterectomy
<input type="checkbox"/>	<input type="checkbox"/>	Bruise easily	<input type="checkbox"/>	<input type="checkbox"/>	Incontinence
<input type="checkbox"/>	<input type="checkbox"/>	Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease
<input type="checkbox"/>	<input type="checkbox"/>	Cancer (If YES, describe what type:)	<input type="checkbox"/>	<input type="checkbox"/>	Liver disease
<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis
<input type="checkbox"/>	<input type="checkbox"/>	Cardiac pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Nursing your child
<input type="checkbox"/>	<input type="checkbox"/>	Cortisone medication/steroids	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis
<input type="checkbox"/>	<input type="checkbox"/>	Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	Pregnant Presently
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes: Type 1 Type 2	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric care
<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	<input type="checkbox"/>	Drug or alcohol dependency	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy or seizures	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems
<input type="checkbox"/>	<input type="checkbox"/>	Fainting/dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	Other disorder(s) not listed above: _____			

List any PRESCRIPTION medication you are **currently** taking (Including: pills, injections, skin patches): _____

Which of the following OVER THE COUNTER medications have you taken in the last week?

- Advil/Motrin/Ibuprofen
- Aleve
- Alternative Medicines
- Antacids
- Antihistamines
- Aspirin
- Decongestants
- Laxatives
- Tylenol
- Vitamins/Mineral Supplements
- Other: _____

Please list known ALLERGIES:

- Latex
- Tape/Adhesive
- Other Skin Allergies
- Medications: _____
- _____
- Other: _____
- _____
- _____

Have you ever been treated by any of the following for THIS problem?

- Acupuncturist
- Massage Therapist
- Osteopath (D.O.)
- Chiropractor
- Medical Doctor (M.D.)
- Physical/Occupational Therapist

- Dentist
- Naturopath
- Psychiatrist/Psychologist
- Other: _____
- _____

Was the treatment successful? Yes No

Are you a smoker? Yes No

If yes, how many packs, on average, do you smoke per day? _____

Do you consume alcohol? Yes No

If yes, how many drinks per day? _____ Per week? _____

What do YOU wish to achieve with physical therapy? (YOUR PERSONAL GOAL(S)): _____