PT NORTHWEST

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
☐	☐	☐		
☐	☐	☐		
☐	☐	☐		
☐	☐	☐		
☐	☐	☐		

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

(Continued on back)

PT NORTHWEST

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	
☐	☐	Anemia	☐	☐	Gastritis/ulcers
☐	☐	Asthma/Emphysema/Bronchitis	☐	☐	Heart (surgery, attack, disease)
☐	☐	Arthritis: Osteo, Rheumatoid	☐	☐	High blood pressure
☐	☐	AIDS/HIV positive	☐	☐	Hepatitis: ☐A ☐B ☐C ☐D
☐	☐	Artificial joints (hip, knee, etc.)	☐	☐	Hemophilia
☐	☐	Anxiety attacks	☐	☐	Hysterectomy
☐	☐	Bruise easily	☐	☐	Incontinence
☐	☐	Chronic cough	☐	☐	Kidney disease
☐	☐	Cancer (If YES, describe what type:)	☐	☐	Liver disease
		_____	☐	☐	Multiple Sclerosis
☐	☐	Cardiac pacemaker	☐	☐	Nursing your child
☐	☐	Cortisone medication/steroids	☐	☐	Osteoporosis
☐	☐	Chest pain	☐	☐	Pregnant ☐ Presently
☐	☐	Diabetes: ☐ Type 1 ☐ Type 2	☐	☐	Psychiatric care
☐	☐	Depression	☐	☐	Stroke
☐	☐	Drug or alcohol dependency	☐	☐	Shortness of breath
☐	☐	Epilepsy or seizures	☐	☐	Thyroid problems
☐	☐	Fainting/dizziness	☐	☐	Tuberculosis

☐ ☐ 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
- ☐ Chiropractor
- ☐ Dentist
- ☐ Other: _____
- ☐ Massage Therapist
- ☐ Medical Doctor (M.D.)
- ☐ Naturopath
- ☐ Osteopath (D.O.)
- ☐ Physical/Occupational Therapist
- ☐ Psychiatrist/Psychologist

_____

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)): _____

_____