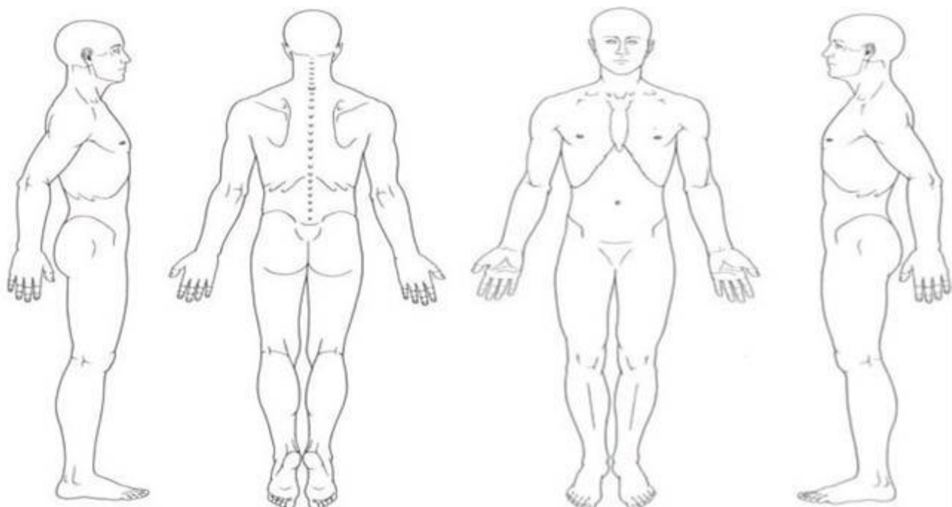
BodyDynamic
physical therapy + pilates + wellness

Physical Therapy Patient Intake Questionnaire

Patient Name____________________________________ Age______ Date of Birth_____________ Date___________
Occupation/Work activities__________________________________________ Currently Working? Yes No Modified
______Commute Time ____Sit more than 50% ____ Lift more than 20# ____Lift more than 50# ____Push ____Pull
How would you rate your general stress level? ☐none ☐minimal ☐moderate ☐high
What is your Health Status? ☐Excellent ☐Good ☐Fair ☐Poor Do you currently Smoke? Yes No _____Packs/day
Sports/Hobbies_______________________________________________________________ Dr.___________________
Hand Dominance R L Stairs @Home Y N

Please indicate your symptoms on the body chart below



___Fall ___Auto Accident ___Hit From Behind ___Hit from Side
___Lifting ___Bending ___Pushing ___At Home
___Pulling ___Twisting ___No Apparent Cause
other________________________________________________________

When did your Symptoms Begin?(date)__________________________
Have you had Surgery for this problem?__Yes___No When?_______
What have you done for treatment thus far? ___Ice ___Heat ___PT
____Stretches ____Chiropractic ____Acupuncture ____Injection
Other________________________________________________________
Medications___________________________________________________
Have you had any special tests? ______ X-rays_____ MRI _____ EMG
_____CT scan; Other___________________________________
Is your sleep disrupted? ___Yes ___No
Are any of your normal activities impaired? ___Yes ___No
What specific activities are limited or impaired since this problem began?
_____________________________________________________________

Have you had similar Symptoms before? ___Yes ___No When? ____
What % did your symptoms resolve? _____
What are your goals for physical therapy?_________________________

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Please list any significant medical problems__________________________________________________________________
Please list any scars and their locations______________________________________________________________________

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**Each column represents an AREA that is a problem, in order of severity.**
**Please Prioritize your areas of complaint from body chart on page 1 using the scale below to rate your pain:**

**Area 1:**_________________________ **Area 2:**_________________________ **Area 3:**_______________________

Pain Scale

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| No Pain | Light Pain, Annoyance, Ache. Able to ignore when busy/occupied | | | More intense pain or ache; can be constant or intermittent. Unable to ignore but can push through, perhaps modifying minimally | | | More severe. Unable to push through. Must modify or avoid positions/activities | | | Go to the Hospital |

Please rate your pain using the scale above for each area **for the last 1 week**: 0 is no pain; 10 is maximum (go to hospital)

**Area 1**: Worst___ Best___ Now___ **Area2**: Worst___ Best___ Now___ **Area3**: Worst___ Best___ Now___

Please use the following columns to describe your complaints:

Area 1: ______________________

☐ pain ☐ache ☐ stiff ☐ burning

☐ numb ☐ weak ☐ limited motion

☐ tight ☐ pins & needles ☐ sharp

**Area 2:** ______________________

☐ pain ☐ache ☐ stiff ☐ burning

☐ numb ☐ weak ☐ limited motion

☐ tight ☐ pins & needles ☐ sharp

Area 3:_______________________

☐ pain ☐ache ☐ stiff ☐ burning

☐ numb ☐ weak ☐ limited motion

☐ tight ☐ pins & needles ☐ sharp

Have Your Symptoms Changed in Any Way? (circle most appropriate) In the last month 2 weeks 1 week other____

____Better ____Worse ____Same ____Better ____Worse ____Same ____Better ____Worse ____Same

How often do you experience your pain/symptoms?

☐ constantly (100%) ☐ frequently(75%)

☐ intermittently (50%)☐occasionally(25%)

☐ constantly (100%) ☐ frequently(75%)

☐ intermittently (50%)☐occasionally(25%)

☐ constantly (100%) ☐ frequently(75%)

☐ intermittently (50%)☐occasionally(25%)

Is your complaint affected by the time of day?

☐ Worse in the morning ☐ evening

☐ other______________________

☐ Better in the morning ☐ evening

☐ other______________________

☐ Worse in the morning ☐ evening

☐ other______________________

☐ Better in the morning ☐ evening

☐ other______________________

☐ Worse in the morning ☐ evening

☐ other______________________

☐ Better in the morning ☐ evening

☐ other______________________

Please circle what area (as numbered above[1,2,3]) of your body **feels worse** after these activities or positions

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1 2 3 | exercise(during) | 1 2 3 | bending forward | 1 2 3 | pushing | 1 2 3 | squatting |
| 1 2 3 | exercise (after) | 1 2 3 | bending backward | 1 2 3 | pulling | 1 2 3 | looking up |
| 1 2 3 | sitting | 1 2 3 | coughing | 1 2 3 | reaching up | 1 2 3 | looking down |
| 1 2 3 | standing | 1 2 3 | sneezing | 1 2 3 | reaching out | 1 2 3 | turning left |
| 1 2 3 | walking | 1 2 3 | stairs (up) | 1 2 3 | twisting | 1 2 3 | turning right |
| 1 2 3 | jogging | 1 2 3 | stairs (down) | 1 2 3 | uneven surfaces | 1 2 3 | Other __________ |
| 1 2 3 | typing | 1 2 3 | driving | 1 2 3 | lifting | | |

Please circle what area (as numbered above [1,2,3]) of your body has **reduced symptoms** after these activities or positions

Please Circle Your Most Comfortable Position

| | | | | | |
|---|---|---|---|---|---|
| 1 2 3 | lying on back | 1 2 3 | medication | 1 2 3 | elevation |
| 1 2 3 | lying on stomach | 1 2 3 | injections | 1 2 3 | compression (ace wrap) |
| 1 2 3 | lying on side | 1 2 3 | heat | 1 2 3 | ice |
| 1 2 3 | walking | 1 2 3 | exercise | 1 2 3 | resting |
| 1 2 3 | sitting | 1 2 3 | standing | 1 2 3 | Other _____________ |