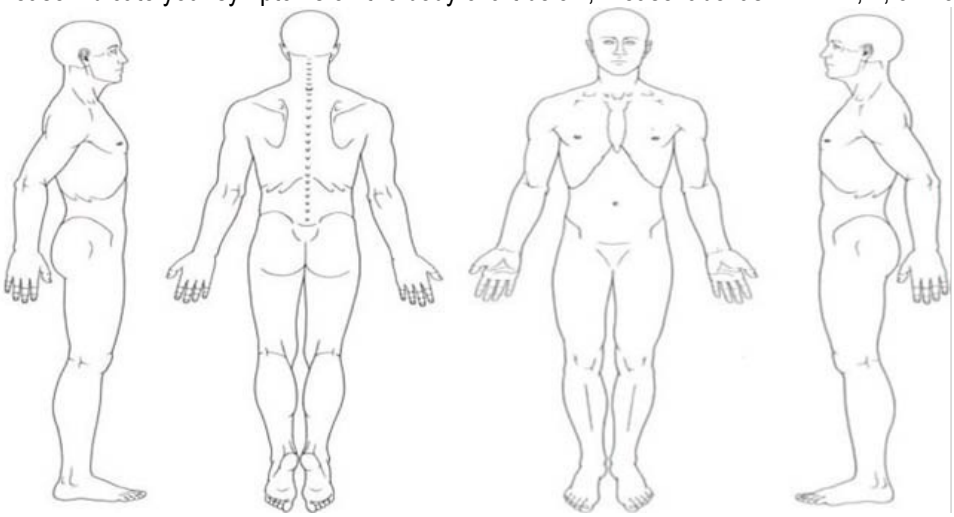
BODYDYNAMIC
physical therapy + pilates + wellness

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, Please label as AREA 1, 2, 3 in order of severity or importance to you.



How did your Problem begin? (Check all that apply)

___Sudden	___Gradually	___During Sports	___At Work
___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?_____

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 Prioritize your AREA of complaint from body chart on page 1 using the scale above to rate your pain:

AREA 1: _____ **AREA 2**:_____ **AREA** 3:_____

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

AREA 1: Worst:____ Best:____ Now:____ **AREA 2**: Worst:____ Best:____ Now:____ **AREA** 3: 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 above) 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 above) 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 _____

Please list any significant medical problems_____
Please list any scars and their locations_____