

## 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

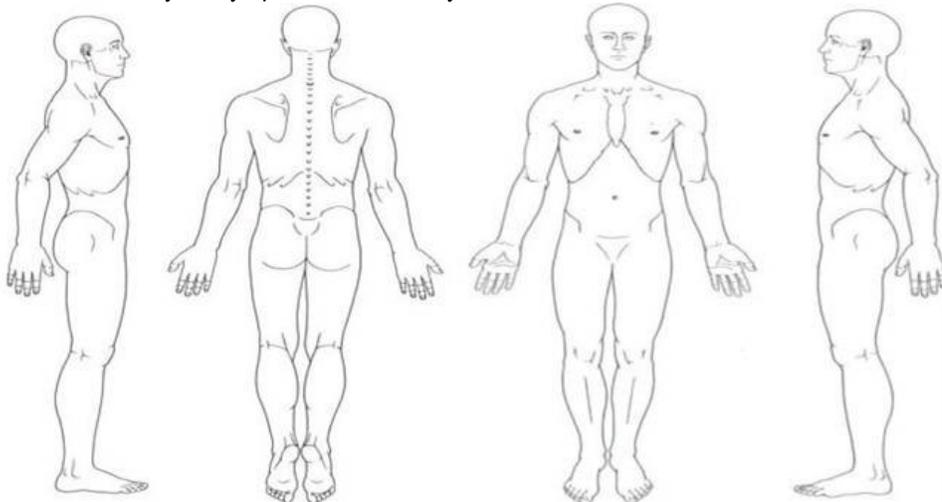
How would you rate your general stress level?  none  minimal  moderate  high

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)

- |                                  |  |  |  |
|----------------------------------|--|--|--|
| <input type="checkbox"/> Sudden  | <input type="checkbox"/> Gradually     | <input type="checkbox"/> During Sports     | <input type="checkbox"/> At Work       |
| <input type="checkbox"/> Fall    | <input type="checkbox"/> Auto Accident | <input type="checkbox"/> Hit From Behind   | <input type="checkbox"/> Hit from Side |
| <input type="checkbox"/> Lifting | <input type="checkbox"/> Bending       | <input type="checkbox"/> Pushing           | <input type="checkbox"/> At Home       |
| <input type="checkbox"/> Pulling | <input type="checkbox"/> Twisting      | <input type="checkbox"/> 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%)  constantly (100%)  frequently(75%)  constantly (100%)  frequently(75%)
- intermittently (50%)  occasionally(25%)  intermittently (50%)  occasionally(25%)  intermittently (50%)  occasionally(25%)

Is your complaint affected by the time of day?

- Worse in the morning  evening  Worse in the morning  evening  Worse in the morning  evening
- other \_\_\_\_\_  other \_\_\_\_\_  other \_\_\_\_\_
- Better in the morning  evening  Better in the morning  evening  Better in the morning  evening
- other \_\_\_\_\_  other \_\_\_\_\_  other \_\_\_\_\_

Please circle what AREA (as above) of your body feels worse after these activities or positions

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

Please circle what AREA (as above) of your body has reduced symptoms after these activities or positions

<u>1 2 3</u> lying on back	<u>1 2 3</u> medication
<u>1 2 3</u> lying on stomach	<u>1 2 3</u> injections
<u>1 2 3</u> lying on side	<u>1 2 3</u> heat
<u>1 2 3</u> walking	<u>1 2 3</u> exercise
<u>1 2 3</u> sitting	<u>1 2 3</u> standing

Please Circle Your Most Comfortable Position

<u>1 2 3</u> elevation
<u>1 2 3</u> compression (ace wrap)
<u>1 2 3</u> ice
<u>1 2 3</u> resting
<u>1 2 3</u> Other _____

Please list any significant medical problems \_\_\_\_\_

Please list any scars and their locations \_\_\_\_\_