

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

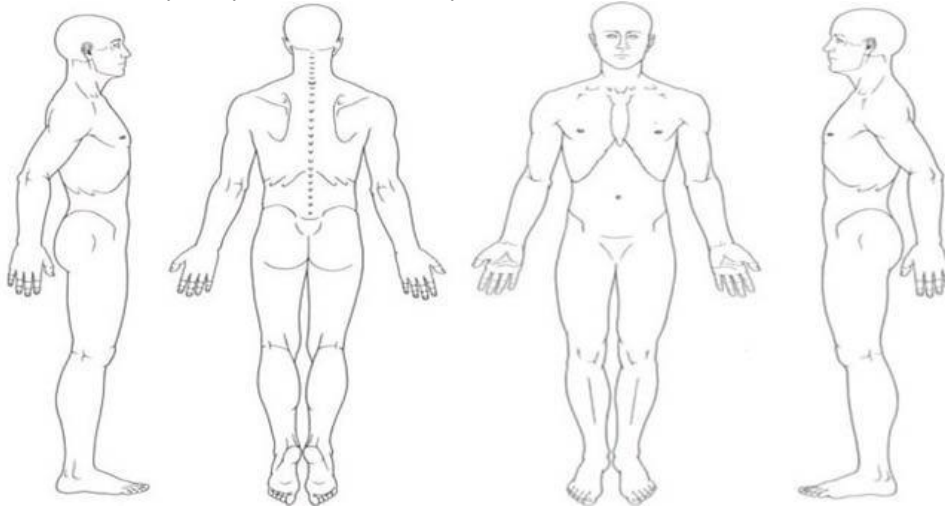
How would you rate your general stress level? ☐ none ☐ minimal ☐ moderate ☐ high

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: Each area is divided by columns & then by numbers for worsening & easing sections.

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: _____	AREA 2: _____	AREA 3: _____
☐ pain ☐ ache ☐ stiff ☐ burning	☐ pain ☐ ache ☐ stiff ☐ burning	☐ pain ☐ ache ☐ stiff ☐ burning
☐ numb ☐ weak ☐ limited motion	☐ numb ☐ weak ☐ limited motion	☐ numb ☐ weak ☐ limited motion
☐ tight ☐ pins & needles ☐ sharp	☐ tight ☐ pins & needles ☐ sharp	☐ 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 the number that corresponds to each AREA (as above) of your body that 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 the number that corresponds to each AREA (as above) of your body that has reduced symptoms after these activities or positions

<u>1 2 3</u> lying on back	<u>1 2 3</u> medication	<u>Please Circle Your Most Comfortable Position</u>
<u>1 2 3</u> lying on stomach	<u>1 2 3</u> injections	<u>1 2 3</u> elevation
<u>1 2 3</u> lying on side	<u>1 2 3</u> heat	<u>1 2 3</u> compression (ace wrap)
<u>1 2 3</u> walking	<u>1 2 3</u> exercise	<u>1 2 3</u> ice
<u>1 2 3</u> sitting	<u>1 2 3</u> standing	<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 _____