Patient Intake Questionnaire

New Life
Portage, WI 53901

Date: __________
Patient's Name: ________________________________
Age: __________ Sex: __________

ABOUT YOUR CURRENT COMPLAINT

1 What is the complaint that brought you here? ________________________________

2 When approximately did this complaint begin? Date: ________ Has it recently worsened? ☐ Yes ☐ No Date: __________

3 What caused this complaint? ________________________________

4 What activities are you unable to do, or do without pain? ________________________________

5 Are you afraid of physical activity? ☐ Yes ☐ No If "yes", why? ________________________________

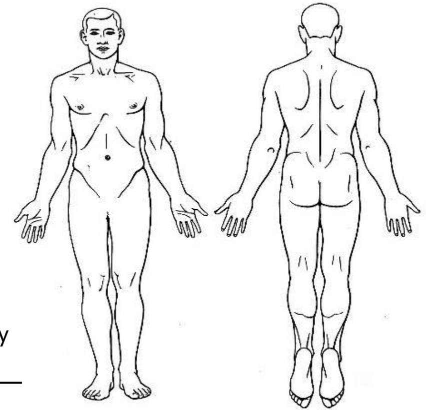
6 What makes this complaint better? ____________________ Worse? ____________________

7 Does this complaint affect you in any of the following? ☐ Mood ☐ Sleep ☐ Activity ☐ Safety

8 What have you felt in the past week, including today? ☐ Sad ☐ Hopeless ☐ Lack of energy ☐ Loss of interest in usual activities

9 What symptoms are you experiencing with this complaint? *Draw areas of symptoms on body diagrams below…*

☐ Swelling / Stiffness ☐ Weakness ☐ Loss of balance or coordination
☐ Loss of motion ☐ Numbness ☐ Ache/Pain
☐ Fatique ☐ Tingling ☐ Other (Specify) ____________________



10 How frequent are the symptoms experienced? ☐ Constant ☐ Intermittant ☐ Occasional

11 How much pain are you experiencing? *(On the scale of 0-10 place a check mark)*

Pain Scale	0	1	2	3	4	5	6	7	8	9	10
	None	◄	Mild	►	◄	Moderate	►	◄	Severe	►	Worst

12 What tests have you had for this complaint?
☐ XRay ☐ CAT Scan ☐ MRI ☐ Myelogram ☐ Bone Scan ☐ Other: __________

13 What treatment have you had for this complaint? ☐ Physical Therapy ☐ Occupational Therapy
☐ Athletic Training ☐ Chiropractic ☐ Alternative Medicine - (Specify): ____________________

14 What is your occupation? ________________________________

Work Status: ☐ Full Time ☐ Part Time ☐ Not Working ☐ Medical Restrictions ☐ Medical Leave Last Date Worked: __________

ABOUT YOUR GENERAL HEALTH

15 Please check all medical conditions that you have, or have had.

☐ Arthritis ☐ Heart Disease ☐ Lung Disease ☐ Difficulty Sleeping ☐ Long term steroid use
☐ Osteoporosis ☐ High Blood Pressure ☐ Diabetes ☐ Fatique ☐ Nausea / Vomiting
☐ Fybromyalgia ☐ Shortness of breath ☐ Stroke ☐ Change in Appetite ☐ Dizziness
☐ Thyroid Disease ☐ Chest Pain ☐ Cancer ☐ Depression/Anxiety ☐ Sexually Transmitted Disease
☐ Fever ☐ Pace Maker ☐ Stomach Disorder ☐ Panic Attacks ☐ Other: ________________
☐ Unexplained Weight Loss/Gain

16 Please check all of the following items that currently or have previously applied to you.

☐ Hearing Problems ☐ Pregnant ☐ Bowel or bladder problems
☐ Visual Problems ☐ Substance Abuse ☐ I have had a fall in the past 12 months that resulted in an injury.
☐ Learning Problems ☐ Smoke ☐ I have had 2 or more falls within the past 12 months in which I was not injured.

17 Please list surgeries: ________________________________

18 Please list allergies: ________________________________

19 Please list medications and dietary supplements you are currently taking? Do you have related questions? ☐ Yes ☐ No

____________________ ____________________ ____________________ ____________________
____________________ ____________________ ____________________ ____________________

20 Are you currently receiving psychological or social serivces? ☐ Yes ☐ No *Do you need help finding services?* ☐ Yes ☐ No

21 Your primary physician's Name: ____________________ Date last seen: ____________________

22 What goals do you want to achieve through treatment? ________________________________

23 Do you exercise regularly? ☐ Yes ☐ No How often? __________ hrs / wk. Type of exercise: __________________

SIGNATURES *Patient:* ____________________________ *Clinician:* ____________________________

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