Patient Intake Questionnaire

Date: _______________

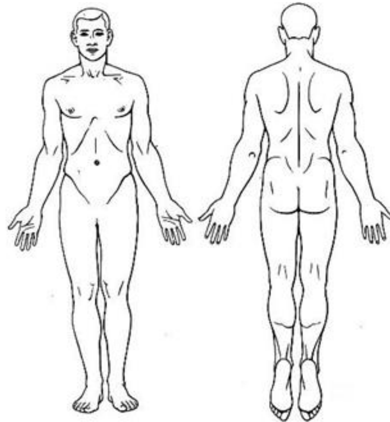
Patient's Name: _____________________________________

Age: ____________ Sex: ____________

ABOUT YOUR CURRENT COMPLAINT

1. What is the complaint that brought you here? ____
2. When approximately did this complaint begin? Date: __________
3. Are symptoms: ☐ Getting Better ☐ Worse ☐ Same
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?
   ☐ Swelling ☐ Stiffness ☐ Loss of balance or coordination ☐ Weakness
   ☐ Loss of motion ☐ Numbness ☐ Ache / Pain
   ☐ Fatigue ☐ Tingling ☐ Other (specify) ______________

Please draw areas of symptoms on the body diagram to the right.



10. How frequent are the symptoms experienced? ☐ Constant ☐ Intermittent ☐ Occasional
11. How much pain are you experiencing on average? *(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 **<u>for this complaint</u>**?
    ☐ X-Ray ☐ CAT Scan ☐ MRI ☐ Myelogram ☐ Bone Scan ☐ Other: ______________
    What were the results of these test(s)? ____
13. What treatment have you had **<u>for this complaint</u>**? ☐ Physical Therapy ☐ Occupational Therapy
    ☐ Athletic Training ☐ Chiropractic ☐ Injection ☐ Alternative Medicine (specify): ______________
14. What is your occupation? ____
    Work Status: ☐ Full Time ☐ Part Time ☐ Not Working ☐ Medical Restrictions ☐ Medical Leave
    Last Date Worked ___________________ ☐ Retired

ABOUT YOUR GENERAL HEALTH

15. Please check all medical conditions that you <u>have</u>, or <u>have had</u>:
    ☐ Arthritis ☐ Lung Disease ☐ High Blood Pressure ☐ Diabetes ☐ Stroke

□ Asthma □ Fibromyalgia □ Headaches □ Thyroid Disease
□ Stomach Disorder □ Panic Attacks □ Hearing Problems □ Visual Problems
□ Learning Problems □ Substance Abuse □ Heart Disease □ Infectious Disease
□ I have had a fall in the past 12 months that resulted in injury.
□ I have had 2 or more falls within the past 12 months in which I was not injured.
□ Long term steroid use □ Pace Maker □ Osteoporosis
□ Change in appetite □ Bowel or bladder problems □ Fever
□ Unexplained Weight Loss/Gain
□ Cancer (active or past?) ____________ If past, how many years cancer free? __________

16. Do you have any of the following conditions?
    □ Difficulty sleeping □ Fatigue □ Nausea / Vomiting
    □ Shortness of breath □ Chest pain □ Dizziness
    If any are checked "yes", is your primary care physician aware of this problem: □ Yes □ No
17. Are you currently or think you might be pregnant? □ Yes (# of weeks) ____________ □ No
18. Please list surgeries: ____
19. Please list allergies: ____
    Are you allergic to latex, adhesives, or have any other allergies? □ Yes (explain)________________ □ No
20. Please list medications and dietary supplements you are currently taking.
    ____
    ____
    For your convenience, you may attach a list of medications instead.
21. Do you smoke or use tobacco? □ Yes □ No If yes, how frequently? __________________________
22. Are you currently receiving psychological or social services? □ Yes □ No
    Do you need help finding <u>these types of</u> services? □ Yes □ No
23. Your primary physician's name: ______________________________ Date last seen: ______________
24. What goals do you want to achieve through treatment? ____
25. Do you exercise regularly? □ Yes □ No How often? ______ hrs/wk.
    Type of exercise: ____
26. Is there anything else we should know about your current condition or past medical history?

____

Social History

27. Where do you currently live? □ Home □ Condo/Apartment □ Group Residence □ Nursing Home
28. Do you live alone? □ Yes □ No
29. Have you ever been a victim of abuse? □ Yes □ No
30. Do you feel safe in your current situation? □ Yes □ No

Change Readiness Assessment

A. How <u>important</u> is it to you to improve your physical health and ability?

1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Not at all important *Very Important*

B. How <u>confident</u> are you that you can improve your physical health and ability?

1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Not at all confident *Very Confident*

C. How <u>desirable</u> is it for you to have help to improve your physical health and ability?

1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Not at all desirable *Very Desirable*

D. What will limit your ability to improve?

□ Knowing How □ Finding time □ Financial resources □ Staying committed

E. Would you like my help? □ Yes □ No

SIGNATURES *Patient*: ___________________________ *Clinician*___________________________