PATIENT INTAKE QUESTIONNAIRE

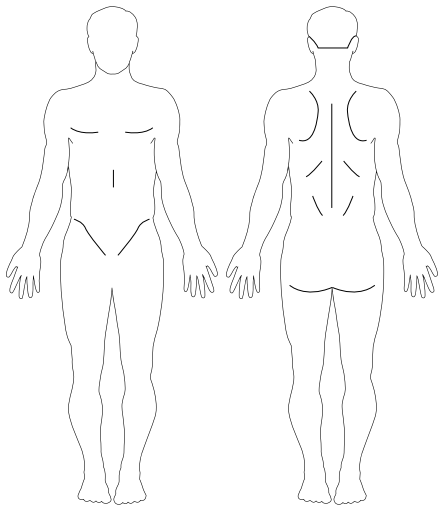
PRO-MOTION Physical Therapy

PATIENT INFORMATION:

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
   ☐Fatigue ☐Tingling ☐Others (Specify)_____



10. How frequent are the symptoms experienced?
    ☐Constant ☐Intermittent ☐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 test have you had for this complaint? ☐X-ray ☐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? _____ Last Date Worked: _____
    Work Status: ☐Full Time ☐Part Time ☐No Working ☐Medical Restrictions ☐Medical Leave

Continue on back of page

ABOUT YOUR GENERAL HEALTH:

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

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

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

☐Pregnant	☐Hearing Problems	☐Bowel or bladder problems	☐Learning Problems
☐Visual Problems	☐Substance Abuse	☐I have had a fall in the past 12 months that resulted in an injury.	
☐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 services? ☐Yes ☐No
Do you need help finding services? ☐Yes ☐No

21. How can we support your spiritual values concerning comfort, stress, or healing? _____

22. Your primary physician's Name: _____ Date last seen: _____

23. What goals do you want to achieve through treatment? _____

24. Do you exercise regularly? ☐Yes ☐No How often? _____hrs/wk. Type of exercise: _____

Patient Signature: _____ **Clinician Signature**: _____

Use space below for additional comments.