PATIENT INTAKE QUESTIONNAIRE

Please tell us as much as possible so that we can understand your health better. Front and Reverse sides

Shoreline Sport & Spine PHYSICAL THERAPY

Date: _____ Patient's Name: _____
First Name *Middle Initial* *Last Name*

Date of Birth: _____ Sex: _____ Email: _____

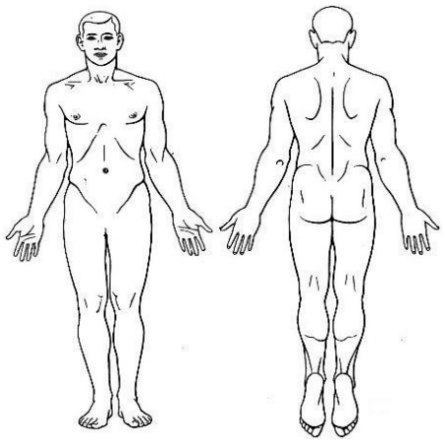
About your current complaint…

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 your stress level, comfort or mood? ☐ yes ☐ no
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 ☐ Weakness ☐ Loss of balance or coordination
☐ Loss of motion ☐ Numbness ☐ Ache/Pain: Draw pain areas on body diagrams ->
☐ Fatique ☐ Tingling



10. How frequent are the symptoms experienced?

☐ Constant ☐ Intermittent

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

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

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 ☐ Not Working ☐ Medical Leave
☐ Part Time ☐ Medical Restrictions Last Date Worked: _____

About your general health:

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

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

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

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

17. Please list all scars & surgeries (continue on back of page): _____

18. Please list allergies: _____

19. Please list medications, vitamins and/or supplements you are currently taking:

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

20. Are you currently receiving psychological or social serivces? ☐ yes ☐ no

Do you need help finding services? ☐ yes ☐ no

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

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

22. Sleep

- How many hours of sleep do you get? _____
- Do you have trouble falling asleep or staying asleep? ☐ yes ☐ no

23. Exercise

- How many days per week do you exercise? _____
- What type of exercise do you do? _____

Questions continued from previous page

Shoreline Sport & Spine PHYSICAL THERAPY

Surgeries & Scars: _____

_____

_____

_____

Previous and Current Joint/Muscle/Bone Injuries/Pain: _____

_____

_____

_____

How did you hear about us?

- ☐ Doctor suggested
- ☐ Friend/Relative suggested
- ☐ Radio
- ☐ Internet
- ☐ I've been here
- ☐ Other _____

We are interested in who our clients are. Please tell us if you are a student, teacher, or administrator

☐ yes ☐ no

If so, which school? _____

Signatures:

Patient: _____ Clinician: _____