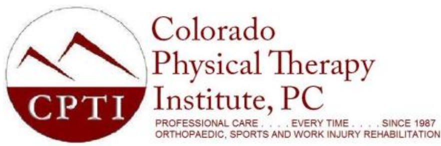


PATIENT INTAKE QUESTIONNAIRE FORM

Thank you for taking the time to complete this questionnaire. The information you give is very important to us and is helpful in providing you with the best possible care. PLEASE FILL IN ALL THE BLANKS.

DATE OF BIRTH _____/_____/_____ DATE OF INJURY _____/_____/_____ **TODAY'S DATE** _____/_____/_____

PATIENT FULL NAME ____

ADDRESS____ CITY________________________________ZIP___________________

Please provide a phone number(s) you can be reached at. Initialing next to them indicated that CPTI can leave a confidential message.

BEST: ( )_______-_____________ Initials: _______ **ALTERNATE** ( )_______-_____________ Initials: _______

In case of an emergency, would you like CPR to be performed to resuscitate you? ☐ NO ☐ YES Initials: _______

WOULD YOU LIKE TO RECEIVE OUR MONTHLY ELECTRONIC HEALTH NEWSLETTER**?** ☐ YES ☐ NO

You will also receive 4 FREE E-books for signing up! E-MAIL ADDRESS____

PERSON TO CONTACT IN CASE OF EMERGENCY__________________________BEST PHONE NUMBER________________

DO YOU HAVE AN ATTORNEY? ☐ NO ☐ YES NAME _____________________PHONE______________________________
(THAT WANTS COPIES OF MEDICAL RECORDS)

EMPLOYER INFORMATION:

YOUR EMPLOYER ____OCCUPATION _____________________________________

CURRENTLY WORKING? ☐ NO ☐ YES ANY RESTRICTIONS? ☐ NO ☐ YES

IF YES, WHAT ARE THEY____

HOW LONG AT JOB? _________ DESCRIBE YOUR JOB DUTIES ____

LIFTING: ☐ YES ☐ NO HOURS______ **STAND**: ☐ YES ☐ NO HOURS________**SIT**: ☐ YES ☐ NO HOURS____________

WALK: ☐ YES ☐ NO HOURS ________ HOURS WORKED IN A SHIFT ________SHIFTS WORKED IN A WEEK ________

TOTAL HOURS WORKED IN A WEEK_________________PRE-INJURY HOURS WORKED PER WEEK _______

CURRENT HOURS WORKED PER WEEK______________

FAMILY PHYSICIAN ____ PHONE ____________________________

REFERRING PHYSICIAN ____ PHONE ____________________________

Height: _______________ Weight: _____________ Do you have stairs at home? ☐ Yes ☐ No (If yes, how many?)_________

1. **What** brings you into our office today?____

2. Please explain **how** your injury happened: ____

____

3. Date of your injury or date when you first noticed symptoms: ____/____/____ ◻ No Known Injury

9. **Where** did your injury or accident occur? ◻ At Work ◻ Motor Vehicle Accident ◻ Other ______________

7. Since the initial onset, my symptoms are (check one): ◻ Improving ◻ Getting Worse ◻ Same

8. Please describe your symptoms, including **intensity** and **frequency**: ______________________

____

11. Describe what, if anything, **helps** to **relieve** your symptoms (treatments, positions, medications): ______________

____

24. What activities make your symptoms worse or are difficult to perform. Be as specific as you can for both **HOME** and **WORK**. ______________________

10. Have you had any similar past injuries or ailments? ◻ No ◻ Yes Please explain: ______________

____

19. Dates of work missed due to injury? ◻ None ◻ From ____________ to ____________

11. Were you hospitalized for this injury/condition? ◻ No ◻ Yes If yes, from _________ to ____________

6. Please check any of following specific tests that have been performed for your PRESENT condition:

◻ X-rays	◻ CAT scan	◻ Halter monitor	◻ Electrocardiogram
◻ MRI	◻ EMG	◻ Nerve conduction	◻ Stress test

◻ Other ____

4.

Previous Surgeries	Date/Year	Previous Surgeries	Date/Year

Any Surgical Complications? ____

13. Due to various <u>insurance benefit limitations</u> it is important to list how many **previous visits** you've attended **<u>this year</u>** of:

Speech therapy: ____________ Physical Therapy: ____________ Chiropractor: ____________

14. Please describe any treatments you have received for your present condition: Include any therapy here or elsewhere; please be specific and include dates. ____

____

25. How many minutes can you do the following **without increased symptoms**? Sit _____ Stand _________ Walk _________

12. What are your hobbies? ____

15. Dominant Hand? ☐ Right ☐ Left

16. Do you smoke? ☐ No ☐ Yes If yes, how many packs/day? ___________________________

18. Do you drink alcohol? ☐ No ☐ Yes If yes, approximately how many drinks per week? __________

26. Please rate the following by using the scale below for **each** area of pain: (example: Knee, Hip, Back)

FIRST Area of Pain: _______________________

	Mild										Severe
Pain-At its worst	0	1	2	3	4	5	6	7	8	9	10
Pain-Current	0	1	2	3	4	5	6	7	8	9	10
Pain- At its best	0	1	2	3	4	5	6	7	8	9	10

Circle all that apply: Burning, sharp, dull/achy, throbbing, shooting, numbness/tingling, constant, intermittent, worse in am/pm.

SECOND Area of Pain (if any): _______________

	Mild										Severe
Pain-At its worst	0	1	2	3	4	5	6	7	8	9	10
Pain-Current	0	1	2	3	4	5	6	7	8	9	10
Pain- At its best	0	1	2	3	4	5	6	7	8	9	10

Circle all that apply: Burning, sharp, dull/achy, throbbing, shooting, numbness/tingling, constant, intermittent, worse in am/pm.

THIRD Area of Pain (if any): _________________

	Mild										Severe
Pain-At its worst	0	1	2	3	4	5	6	7	8	9	10
Pain-Current	0	1	2	3	4	5	6	7	8	9	10
Pain- At its best	0	1	2	3	4	5	6	7	8	9	10

Circle all that apply: Burning, sharp, dull/achy, throbbing, shooting, numbness/tingling, constant, intermittent, worse in am/pm.

23. **Current stress level**

Mild 0 1 2 3 4 5 6 7 8 9 10 **Severe**

20. Please check any **FAMILY** history of:

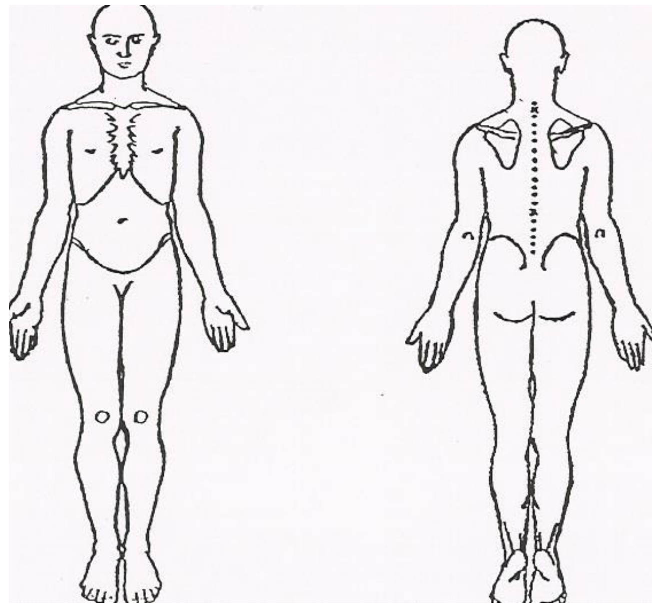
☐ Heart disease ☐ Osteoporosis ☐ Rheumatoid arthritis
☐ Diabetes ☐ High blood pressure ☐ Osteoarthritis
☐ Cancer ☐ Gout ☐ Thyroid disease
☐ Psoriasis ☐ Hemophilia ☐ **NONE OF THE ABOVE**

21. Please check and **PERSONAL** history of:

☐ How many falls in the past 12 months?_______ ☐ Allergies_________________ ☐ HIV/AIDS
☐ Alzheimer's ☐ Cauda Equina ☐ Cerebral Vascular Accident ☐ Heart condition ___________
☐ Diabetes Type I ☐ Current Infection ☐ High blood pressure ☐ Arthritis
☐ Diabetes Type II ☐ Cancer __________ ☐ Huntington's Disease ☐ Tumors____________
☐ Fracture or Suspicion ☐ Seizures ☐ Osteoarthritis ☐ Osteoporosis
☐ Metal implants ☐ Pacemaker ☐ Shortness of breath ☐ Blood Clots
☐ Pneumonia ☐ **Pregnant**

27. Using the body diagram below, please indicate the location of any of the sensations listed. Mark the areas on the drawings with the symbol that best describes the sensation that you feel.

+++ **Sharp pain** ---- **Numbness** /// **Dull pain** **ooo Pins and Needles** xxx **Burning pain**



28. MY GOALS OF PHYSICAL THERAPY INCLUDE: (PLEASE BE SPECIFIC)

a.) Return to the following activities (include home, work and recreation):

_____________________________________ _____________________________________

_____________________________________ _____________________________________

29. Medications that you are currently taking. Please include ALL:

1) Prescriptions 2) Over the Counter Medications 3) Vitamins/Supplements 4) Herbals

Medication	Dose	Times/Day

OneDrive:FO:Patient Intake Questionnaire Form:03/26/18

THANK YOU ONCE AGAIN FOR PROVIDING US WITH THE ABOVE INFORMATION!