Orthopedics
PHYSICAL THERAPY

Patient Intake Questionnaire

Patient Name _____ Date_____

Date of Birth _____ Age_____ Sex_____

About your current complaint:

1. What is the complaint that brought you here? _____
2. When did this complaint begin, or recently become worse? _____
3. What caused this complaint? _____
4. Does this complaint affect your activity choice, tolerance, efficiency, or effectiveness?
   ☐ Yes ☐ No
   If "Yes," what activities? _____
5. What makes this complaint better?_____
   Worse?_____
6. Does this complaint affect your comfort, mood, or ability to sleep? ☐Yes ☐No
7. What symptoms are you experiencing with this complaint?
   ○ Swelling ○ Loss of balance or co-ordination
   ○ Loss of Motion ○ Numbness ○ Pain
   ○ Weakness ○ Tingling ○ Other: Specify_____
8. How frequent are the symptoms experienced?
   ○Constant ○Intermittent
9. How much pain are you experiencing?
   ○ None ○ Very Mild ○ Mild ○ Moderate ○ Severe ○ Very Severe
10. What tests have you had for this complaint?
    ○ Xray ○ CAT Scan ○ MRI ○ Myelogram ○ Bone Scan
11. What treatment have you had for this complaint?
    ○ Physical Therapy ○ Occupational Therapy ○ Chiropractic
12. Is this complaint work related? ○Yes ○No
    If yes: ○ Full Time ○ Part Time ○ Working ○ Medical Restrictions
    ○ Medical Leave Last Date Worked: _____
13. Is this complaint auto related? ○Yes ○No

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About your general health:

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

○ Arthritis	○ Heart Disease	○ High Blood Pressure	○ Lung Disease
○ Cancer	○ Anxiety	○ Pace Maker	○ Panic Attacks
○ Diabetes	○ Depression	○ Thyroid Problems	○ Stroke
○ Stomach Cancer		○ Other: _____	

15. Please check all of the following items that currently apply to you:

○ Hearing Problems	○ Pregnant
○ Visual Problems	○ Bowel or bladder control
○ Learning Problems	○ Smoke

16. Please list surgeries: _____

17. Please list allergies: _____

18. Please list all medications you are currently taking:

_____ _____

_____ _____

_____ _____

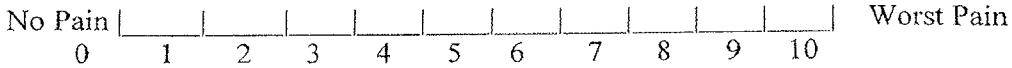
19. What goals do you wish to achieve through treatment? _____

_____

Pain Scale

Please indicate your current level of pain on the scale provided below with 0 being no pain and 10 being the worst imaginable pain.

VAS Self-Report



I have provided the above information about my medical history and agree to receive services/treatment from Orthopedics Plus Physical Therapy.

Signature _____ **Date** _____