PROVIDENCE
Gorge Spine and
Sports Medicine

Patient Intake Questionnaire

To ensure you receive a complete and thorough evaluation, please provide us with the important background information on this form. If you do not understand a question, your therapist will assist you. Thank you.

NAME: _____ **DATE:** _____

Reason you are attending physical therapy? _____

When did symptoms start? _____

What **caused** your condition? _____

Have you had **similar symptoms** before? □ Yes □ No

If **Yes**, how were they treated? _____

Other **treatment** received **for this episode?** _____

Diagnostic tests **for this condition completed?** □ Yes □ No

If **Yes;** Test completed: _____ Date: _____ Results: _____

Surgical Procedure(s) related to present condition? □ Yes □ No

If **Yes,** list Procedure: _____ Surgical Date: _____

Prior Functional Status (before this episode): □ **Independent** (able to do all daily activities)

□ **Assisted:** I used a □ **Cane** □ **Crutch** □ **Walker** ***and/or*** □ I've needed help with: _____

I learn best by (mark all that apply)**:** □ Listening □ Reading □Observation □ Performance

Pain from Current Condition

Rate your **average pain** or symptom(s) on a scale of 0-10 with **"0" equals no pain** and **"10" equals worst imaginable**

→ Mark the line at the point that represents your pain or symptom.

0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10

What % of day are you experiencing this pain?

□ 0-25% □ 26-50% □ 51-75% □ 76-100%

Pain Description: (mark all that apply) □ Constant □ Frequent
□ Intermittent □ Occasional □ Throbbing □ Sharp □ Tingling
□ Dull Ache □ Burning □ Numbness □ Pain with Movement
□ Radiating to _____

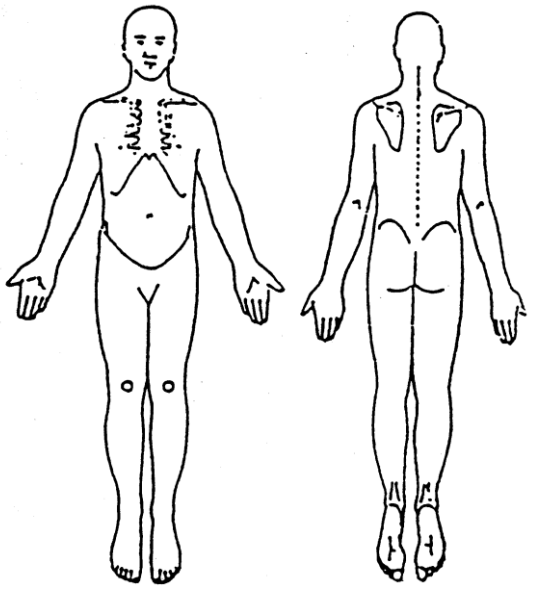
Time of the day symptoms are worse: _____

Symptoms increase with: _____

Symptoms are better with: _____

Overall my symptoms are: □ Better □ Same □ Worse

Please mark the area(s) of symptoms below for this episode



Have you had difficulty with or are you experiencing:

(mark all that apply)□ Balance/Falls □ Walking □ Dizziness/lightheadednes
□ Weakness □ Nausea □ Fainting □ Clumsiness/Loss of muscle control
□ Incontinence or in ability to urinate □ Other _____

Please See Reverse Side

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Past Medical History

Please mark any of the following conditions that you have or have been diagnosed with in the past.
Describe as necessary:

- □ **Cancer** _____
- □ **Lung/Breathing Problems** _____
- □ **Seizure** _____
- □ **Arthritis** _____
- □ **Infectious Disease** _____
- □ **Kidney Disease** _____
- □ **CVA/Stroke** _____
- □ **High Blood Pressure** _____
- □ **Thyroid Disease** _____
- □ **Depression** _____
- □ **Diabetes** _____
- □ **Heart Disease** _____
- □ **Multiple Sclerosis** _____
- □ **Chemical Dependency** _____
- □ **Other conditions you would like us to be aware of:** _____

SURGERIES/HOSPITALIZATIONS:

Date	Type of surgery
_____	_____
_____	_____
_____	_____

INJURIES (Fractures/dislocations/etc)**:**

Date	Type of Injury
_____	_____
_____	_____
_____	_____

Do you have any **allergies? Drugs** _____ **Food** _____ **Other** _____
Do you **smoke cigarettes** or use **tobacco products?** □ Yes □ No **Do you drink alcohol?** □ Yes □ No
Do you **drink coffee** or **caffeinated beverages?** □ Yes □ No
Are you **currently** on **any medications?** □ Yes □ No If **yes,** please list **medication(s)** (or attach a list): _____
_____
_____
_____

Work History: Occupation: _____

Demands of your job: □ Lift □ Overhead work □ Push □ Pull □ Walk □ Drive □ Carry □ Grip □ Squat
□ Prolonged sitting □ Prolonged standing □ Phone □ Prolonged speaking □ Computer □ Travel

Current work status: □ Full duty □ Light duty □ Modified duty/job restrictions are: _____
□ Temporary disability □ Permanent disability □ Applied for disability