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 occupational 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: _____

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**

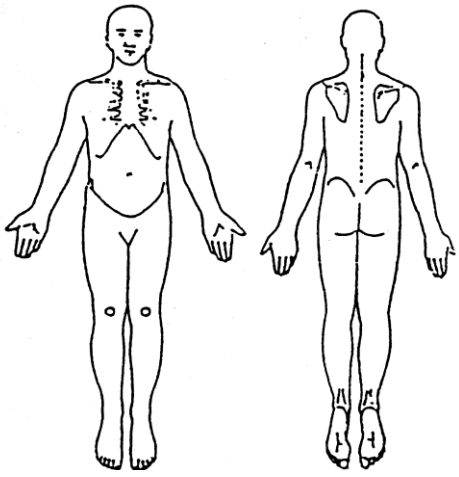
→ **Mark the line at the point that represents your pain or symptom.**

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 _____

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



Time of the day symptoms are worse: _____

Symptoms increase with: _____

Symptoms are better with: _____

Overall my symptoms are: □ Better □ Same □ Worse

Have you had difficulty with or are you experiencing:

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

Please See Reverse Side

PROVIDENCE
Gorge Spine and
Sports Medicine

Patient Intake Questionnaire

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