# Patient Intake Form

Patient’s Name: Date of birth:

SSN \_\_\_\_\_ Sex: □ Female □ Male □ Non-Binary

Home Phone \_\_\_\_ \_\_\_\_Work phone \_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone: \_\_\_\_ \_\_\_\_\_\_\_\_ Contact Preference: □Home □Work □ Cell

E-mail Address \_\_\_\_\_\_

Marital Status: □ Single □ Married □ Divorced □ Widowed

Mailing Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_State Zip

Billing Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_□ Same as Mailing

City \_State Zip

 Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Primary Physician:

Referring Physician:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Relationship

Emergency Contact Phone #

 Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Parent/Guardian Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Patient Questionnaire/Health History

Patient Name: Date:

 Height: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please fill out to your best ability. If you do not understand the question, your therapist will assist you. Thank you!

***IF* YOU HAD AN ACCIDENT, PLEASE COMPLETE THIS SECTION**

Date of accident □ Auto □ Work □ Other State in which injury occurred

Claim number Insurance company (worker’s comp or auto PIP)

Address Claims Adjuster Phone #

Referring Provider:

History of Present Condition:

What are your current symptoms?

Please indicate the area of pain or abnormal sensation on the body chart below (shade in the appropriate area)



When did your symptoms begin? Was onset gradual or sudden : □ Gradual □ Sudden

Since onset are symptoms getting:

□ better □ worse □ not changing

Have you had similar symptoms in the past? YES NO Have you had more than one episode? YES NO

Which of the following best describes how your injury occurred? (If your condition is post-surgical, please indicate as per original injury)

* Lifting □ Blow to the face
* MVA (car accident) □ Throwing
* A fall □ An incident at work
* Overuse (cumulative trauma) □ Degenerative process
* During recreation/sports □ Unknown
* Trauma □ Other

Nature of pain/symptoms (check all that apply)

|  |  |  |
| --- | --- | --- |
| □ sharp | □ aching | □ constant |
| □ dull | □ periodic | □ other  |
| □ throbbing | □ occasional |   |

Throughout the day do your symptoms: (check one)

□ increase □ decrease □ stay the same

Does the pain wake you at night? YES NO Since onset of your current symptoms have you had:

* any difficulty with control of bowel or bladder function
* fever/chills
* any numbness in the genital or anal area
* numbness in arms or legs
* any dizziness or fainting attacks
* weakness
* unexplained weight change
* night pain/sweats
* malaise (vague feeling of bodily discomfort)

□ problems with vision/hearing

* none of these

Have you had any previous treatment for this condition?

Have you had any imaging done? (x-rays, MRI, CT scan)

## Past Medical History

Have you ever been diagnosed with any of the following conditions? (check all that apply)

□ Cancer (type) □ Heart problems

What aggravates your symptoms? (check all that apply)

□ sitting □ repetitive activities

□ going to/rising from sitting □ household activities

□ lying down □ standing

□ walking □ squatting

□ up/down stairs □ sleeping

□ reaching overhead □ coughing/sneezing

* reaching in front of body □ taking a deep breath

□ reaching behind back □ looking up overhead

* reaching across body □ swallowing
* talking, chewing, yawning □ stress
* Depression □ High blood pressure
* Stroke □ Lung problems
* Kidney problems □ Blood disorders

□ Thyroid problems □ Epilepsy/seizures

□ Diabetes □ Allergies

□ Multiple Sclerosis □ Rheumatoid arthritis

□ Head injury □ Osteoporosis

□ Stomach problems □ Broken bones

□ Parkinson’s disease □ Circulation/vascular

* Infectious diseases problems

□ Arthritis □ Other

Do you smoke? If yes, how much? \_

* recreational sports including □ sustained bending
* other:

What relieves your symptoms? (check all that apply)

* sitting □ rest □ massage
* heat □ standing □ medication
* cold □ walking □ nothing
* stretching □ exercise □ other

□ wearing a □ lying down

splint/orthosis

## Medication

Please list any prescription medications you are currently taking (pain pills, injections and/or skin patches, etc.):

Are you currently pregnant?

## Work History

Occupation: Physical Activities at work (check all that apply)

□ sitting □ computer use

* standing □ heavy equipment operation
* phone use □ driving
* repetitive lifting □ other
* heavy lifting

Are you currently receiving or seeking disability for this condition?

YES NO

## General Health

How would you rate your general health?

□ Excellent □ Good □ Average □ Poor

Do you exercise outside of normal daily activity?

* 5+ days/wk □ 1-2 days/wk □ none
* 3-4 days/wk □ occasionally

Exercise, Sports/Recreation consists of: \_

If not performing your normal activities at work, do you plan to RETURN to your previous activity level?

YES NO

Pain rating: Please rate your pain using the numeric scale listed below. A rating of “0” means you have no pain. A rating of “10” means your pain is unbearable and you should go to the ED.

Please circle your pain at it’s worst and your pain presently.

0 1 2 3 4 5 6 7 8 9 10

No pain Moderate Pain Intense Pain