Patient Intake Form

Demographics:

1. Last Name: ____________________ First Name: ______________________ Middle Initial: _______
2. Age: _________
3. Gender (Please place an "X" next to your selection): Male: ____ Female: ____ Other: ____
4. Race/Ethnicity (Please select one): African American: ____ Asian: ____ Caucasian (White): ____ Eskimo/Inuit: ____ Hispanic/Latino: ____ Native American: ____ Other: ____ Declined: ____
5. Education Level (Please select the highest level attained): No high school diploma: ____ High school graduate or GED: ____ Some college no degree: ____ Occupation/technical/vocational school: ____ Associate degree: ____ Bachelor's degree: ____ Master's Degree: ____ Professional school degree (e.g. M.D. or J.D.): ____ Doctoral degree (e.g. PhD): ____ Declined: ____ Unknown: ____
6. Employment Status: Working now: ____ Looking for work, unemployed: ____ Sick leave or maternity leave: ____ Disabled permanently or temporarily due to the condition you are receiving treatment for: ____ Disabled for other reasons: ____ Student: ____ Temporarily laid off: ____ Retired: ____ Keeping house: ____ Other, Specify: __________________________

Social History:

7. How would you rate your general health over the past 2 weeks?

   Excellent: _____ Good: _____ Fair: _____ Poor: _____

8. How limited is your ability to participate in social activities over the past 2 weeks?

   Severely: _____ Moderately: _____ Minimally: _____ Normal: _____

9. How limited is your ability to participate in recreational activities over the past 2 weeks?

   Severely: _____ Moderately: _____ Minimally: _____ Normal: _____

10. How would you describe your smoking status/tobacco use?

    Never smoked/used tobacco: _____ Current user: _____ Quit: _____

    Current users: How long have you smoked? __________ How many packs per day? __________

11. In the past year, have you used drugs (prescription/non-prescription) or drank more than you meant to?

    Never: _____ Rarely: _____ Sometimes: _____ Often: _____

12. In the past year, have you felt you wanted/needed to cut down on your drinking/drug use?

    Never: _____ Rarely: _____ Sometimes: _____Often: _____

13. Do you exercise? Yes: _____ No: _____. If yes, what do you do for exercise? ____________________

____

14. How often do you exercise (please circle your response)?

    0 to 1 time per week   2 to 3 times per week   4 to 6 times per week   Daily

15. How hard do you exercise (select “take it easy” if you don’t exercise)?

    Take it easy   Moderately hard   Heavy breath and sweating   Push near exhaustion

16. How long do you exercise?

    30 minutes or less: ____ Greater than 30 minutes: ____

17. How would you describe your nutritional habits?

    Very poor: ____ Poor: ____ Fair: ____ Good: ____ Very good: ____

18. Please rate your level of difficulty falling asleep over the past two weeks.

    None: ____ Mild: ____ Moderate: ____ Severe: ____ Very Severe: ____

19. Please rate your level of difficulty staying asleep over the past two weeks.

    None: ____ Mild: ____ Moderate: ____ Severe: ____ Very Severe: ____

Past Medical History:

20. Have you ever been told you have any of the following?

Cancer	Yes	No	Ulcers	Yes	No	Diabetes	Yes	No
Heart problems	Yes	No	Infectious diseases	Yes	No	Osteoporosis	Yes	No
High Blood Pressure	Yes	No	Lung problems	Yes	No	Thyroid problems	Yes	No
Angina/Chest Pain	Yes	No	Hepatitis	Yes	No	Rheumatoid arthritis	Yes	No
Asthma	Yes	No	Anemia	Yes	No	Osteoarthritis	Yes	No
Fibromyalgia	Yes	No	Allergies	Yes	No	Depression	Yes	No
Kidney disease	Yes	No	Stroke	Yes	No	Seizures/Epilepsy	Yes	No

21. Please list any other medical issues not listed above or past surgeries:

____

____

22. Please list any medications related/unrelated to your present complaint that you are currently taking:

____

____

____

Please answer the following questions:

Thinking about the **last 2 weeks** place a mark next to your response for the following questions.

	Disagree	**Agree**
23. My current pain has spread to other body regions at some time in the last 2 weeks.	____	____
24. I have had pain in other body regions other than my primary current pain.	____	____
25. I have only walked short distances because of my current pain.	____	____
26. In the last 2 weeks, I have dressed more slowly than usual because of my current pain.	____	____
27. I can't do all the things normal people do because it's too easy for me to get injured.	____	____
28. I worry too much over something that really doesn't matter.	____	____
29. It's terrible, and I think it's never going to get any better.	____	____
30. Little interest or pleasure in doing things.	____	____

31. Overall, how bothersome has your current pain been in the last 2 weeks?

Not at all	Slightly	Moderately	Very Much	Extremely
____	____	____	____	____

Please rate the truth of the statement below as it applies to you.

32. It is OK to experience pain.

Never True						**Always True**
0	1	2	3	4	5	6

Please rate your degree of certainty in performing various tasks during rehabilitation based on the following statement.

33. My therapy no matter how I feel emotionally

I Cannot Do It										**Certain I Can Do It**
0	1	2	3	4	5	6	7	8	9	10

<u>CONSENT</u>: To the best of my knowledge, the information I have provided above is accurate and complete. I understand that the information I have provided will be used to help make informed decisions about my physical therapy diagnosis, prognosis, and treatment plan. By signing this form, I agree to participating in a PT examination to determine if my condition is appropriate for PT. I also agree to receiving treatment for my condition in the event a PT examination identifies that my condition is appropriate for conservative care. I understand that I have the right to refuse treatment or stop care at any time.

______________________________ ____________________

(Signature) (Date)