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 many days of work have you missed because of pain during the past 18 months? (check one): ____ 0 days, ____ 1-2 days, ____ 3-7 days, ____ 8-14 days, ____ 15-30 days, ____ 1 month, ____ 2 months, ____ 3 months, ____ 3-6 months, ____ 6-12 months, ____ Over 1 year
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. Do you exercise? Yes: _____ No: _____. If yes, what do you do for exercise and how much?

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

    Never: _____ Rarely: _____ Sometimes: _____ Often: _____
13. In the past year, have you felt you wanted/needed to cut down on your drinking/drug use?

    Never: _____ Rarely: _____ Sometimes: _____Often: _____

Past Medical History:

14. 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

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

_____

_____

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

_____

_____

_____

16. Please indicate your usual level of pain **during the past week**.

0 1 2 3 4 5 6 7 8 9 10

No Pain **Worst Pain Possible**

17. Does pain, numbness, tingling or weakness extend into your leg (from the low back) and/or arm (from the neck)?

0 1 2 3 4 5 6 7 8 9 10

None of the time **All of the time**

18. How would you **rate your general health**?

0 1 2 3 4 5 6 7 8 9 10

Poor **Excellent**

19. If you had to spend the rest of your life with your condition **as it is right now**, how would you feel about it?

0 1 2 3 4 5 6 7 8 9 10

Delighted **Terrible**

20. How anxious (e.g., tense, uptight, irritable, fearful, difficulty in concentrating/relaxing) have you. Been feeling **during the past week**?

0 1 2 3 4 5 6 7 8 9 10

Not at all **Extremely anxious**

21. How much have you been able to control (i.e., reduce/help) your pain/complaint on your own **during the past week**?

0 1 2 3 4 5 6 7 8 9 10

I can reduce it **I can't reduce it at all**

22. Please indicate how depressed (e.g., down in the dumps, sad, downhearted, in low spirits, pessimistic, feelings of hopelessness) you have been feeling **in the past week**.

0 1 2 3 4 5 6 7 8 9 10

Not depressed at all **Extremely depressed**

23. On a scale of 0 – 10, how certain are you that you will be doing normal activities or working in **six months**?

0 1 2 3 4 5 6 7 8 9 10

Very certain **Not certain at all**

24. I can do light work for an hour.

0 1 2 3 4 5 6 7 8 9 10

Completely agree **Completely disagree**

25. I can sleep at night.

0 1 2 3 4 5 6 7 8 9 10

Completely agree **Completely disagree**

26. An increase in pain is an indication that I should stop what I am doing until the pain decreases.

0 1 2 3 4 5 6 7 8 9 10

Completely disagree **Completely agree**

27. Physical activity makes my pain worse.

0 1 2 3 4 5 6 7 8 9 10

Completely disagree **Completely agree**

28. I should not do my normal activities, including work, with my present pain.

0 1 2 3 4 5 6 7 8 9 10

Completely disagree **Completely agree**

29. Please identify ***three important activities*** that you are unable to do or are having ***difficulty with today.*** Please use the scale below to rate your ability to perform each activity.

0 1 2 3 4 5 6 7 8 9 10

Unable to Perform **Able to perform at prior level**

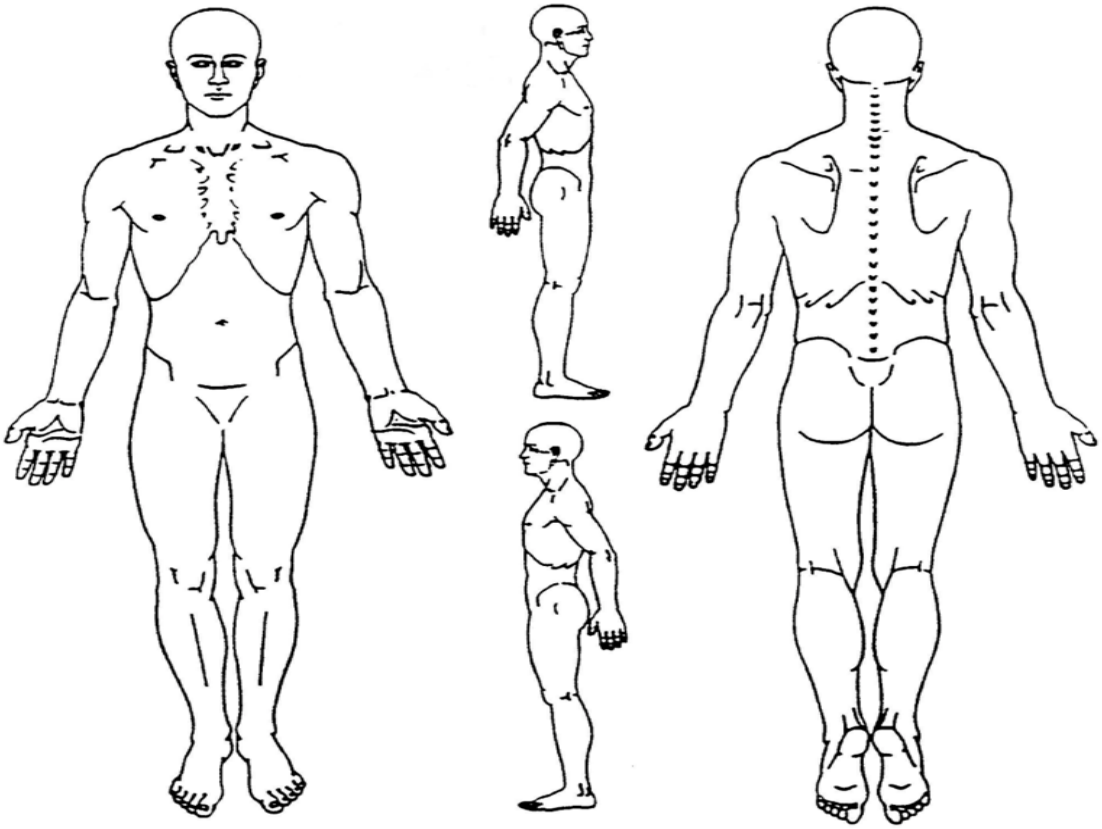
1. _____ Score: _____
2. _____ Score: _____
3. _____ Score: _____

30. Please indicate on the diagram the location of symptoms over the past 24 hours.

1) *Shade (color)* in the areas in which you are feeling **Pain.**

2) *Circle* the areas in which you are feeling **tingling, prickling, or burning.**

3) *Label* the area(s) with a **"N"** in which you feel **numbness, heaviness, or other.** *Label* the area(s) **"S"** in which you feel **sudden/stabbing pain.** *Label* the area(s) **"P"** in which you feel **pressure.**



CONSENT: 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)