Intake Questionnaire

Name: _____ Date: _____ Phone: _____
Address: _____
Date of Birth _____ Email: _____
Insurance: _____ Occupation: _____
Referral from: _____
Primary MD: _____
Reason for Referral: _____
Date of onset: _____

List all activities that you cannot do because of your current problem: "current level of function":
_____
_____

What activities make your problem worse?
_____
_____

What function(s) do you hope to change by coming to therapy? What are your Goals?
_____
_____

Pain Questionnaire

History of Onset
When did this current episode of pain begin? _____
Did the pain/problem begin: [] gradually [] suddenly

How did this episode of pain begin?
[] bending [] twisting [] lifting [] pushing/pulling
[] motor vehicle accident [] other _____

If your pain is due to an injury, briefly describe the events that led to the injury.
_____
_____

Have you had prior episodes of this pain/problem? [] Yes [] No
If yes, how many episodes have you had? _____
When did the first episode begin? _____
Is this episode worse than the previous episode? _____
Explain what caused the prior episodes: _____

Where are you experiencing your pain? (check all that apply)
[] back [] hip [] thigh []knee [] lower leg [] neck
[] ankle/foot [] shoulder [] upper arm [] pelvic area [] elbow [] wrist/hand

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Use the diagram and symbols to indicate where your pain is.

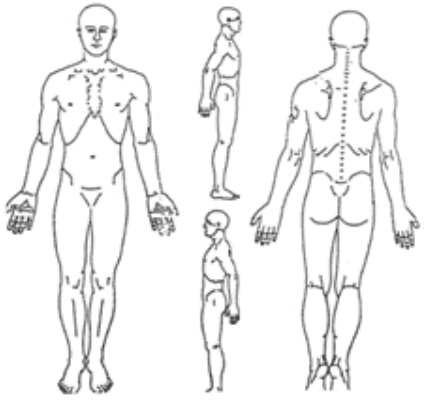
Ache: AAA

Burning: XXX

Numbness: OOO

Pins/Needles: …

Stabbing: ///



Please check the activities tht affect the pain/problem.

	Better	Worse	No Change
Coughing	[ ]	[ ]	[ ]
Sneezing	[ ]	[ ]	[ ]
Straining	[ ]	[ ]	[ ]
Standing	[ ]	[ ]	[ ]
Walking	[ ]	[ ]	[ ]
Sitting	[ ]	[ ]	[ ]
Lifting	[ ]	[ ]	[ ]
Pushing/Pulling	[ ]	[ ]	[ ]
Driving	[ ]	[ ]	[ ]
Bending Forward	[ ]	[ ]	[ ]
Lying on Stomach	[ ]	[ ]	[ ]
Overhead Reaching	[ ]	[ ]	[ ]
Squatting	[ ]	[ ]	[ ]
Kneeling	[ ]	[ ]	[ ]
Typing/Writing	[ ]	[ ]	[ ]
Intercourse	[ ]	[ ]	[ ]

Please circle the number that best represents your level of pain.

What is the WORST?

0 1 2 3 4 5 6 7 8 9 10

What is it TODAY?

0 1 2 3 4 5 6 7 8 9 10

What is the LEAST?

0 1 2 3 4 5 6 7 8 9 10

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Medical History

If you had surgery for this or a different problem, complete the following for each operation.

Surgery Type	Date	Worse	Same	Better	Type of Improvement
_____	_____	[ ]	[ ]	[ ]	_____
_____	_____	[ ]	[ ]	[ ]	_____
_____	_____	[ ]	[ ]	[ ]	_____

Please check all that apply to you.

[ ] Rheumatoid Arthritis
[ ] Osteoarthritis _____
[ ] Diabetes Type I or 2
[ ] Cancer _____
[ ] Tuberculosis
[ ] Stroke
[ ] Sexually transmitted diseases or HIV/AIDS
[ ] Hepatitis A, B, C
[ ] Osteoporosis or Osteopenia
[ ] Currently Pregnant or attempting pregnancy
[ ] Thyroid Condition
[ ] Liver disease
[ ] Poor balance or recent falls
[ ] Dizziness/vertigo/fainting/blackouts
[ ] Severe headaches
[ ] Gastrointestinal issues (IBS, Crohn's)
[ ] Abdominal pain/bloating/gas
[ ] Heartburn/GERD
[ ] Gout
[ ] Depression
[ ] Psychological _____
[ ] Chemical dependency (i.e. alcoholism or drugs
[ ] Food intolerance _____
[ ] Other _____

[ ] Congenital heart defect
[ ] Heart problems/heart disease
[ ] High or low Blood Pressure
[ ] Pacemaker
[ ] Chest pain/angina/palpitations
[ ] Circulation problems or blood clots
[ ] Bronchitis/pneumonia
[ ] Emphysema
[ ] Asthma
[ ] Bleeding disorders
[ ] Using blood thinners
[ ] Toxoplasmosis
[ ] Fibromyalgia
[ ] Recurrent muscle/ joint pain
[ ] Kidney disease/stones
[ ] Prostate problems
[ ] Lyme disease, tick related diseases
[ ] Multiple sclerosis
[ ] Epilepsy/seizure disorders
[ ] Anemia
[ ] Latex Allergy
[ ] Skin problems _____
[ ] Menopause

Review of Systems: During the past year, have you had any of the following?

[] Unexplained Fevers	[] Chest Pain/Tightness	[] Night Sweats	[] Trouble Breathing
[] Excessive Fatigue	[] Persistent Cough	[] Hoarseness	[] Change in appetite
[] Stiffness in Joints	[] Swollen Ankles/Legs	[] Depression	[] Unexplained Weight Loss
[] Black/Bloody Stool	[] Painful Urination	[] Anxiety	[] Difficulty swallowing
[] Change in Bowel Habits	[] Blood in urine	[] Change in menstruation	[] Unusual Stress in Work Life
[] Joint Swelling/Warmth	[] Urinary Incontinence	[] Easy Bruising	[] Unusual Stress in Home Life
[] Nodes (groin/armpit/neck)	[] Difficulty Sleeping	[] Unusual discharge from vagina/penis	

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During the past month have you often been bothered by feeling down, depressed, or hopeless? ? [ ]Yes [ ] No
During the past month, have you often been bothered by little interest or pleasure in doing things? [ ]Yes [ ] No
Is this something with which you would like help? [ ] Yes [ ] Yes, but not today [ ] No

Allergies (please list)

_____
_____

Injury History: Include work or non-work injuries (fractures, major sprains or major injuries with no specific diagnosis):

_____
_____

Which special tests performed have been performed with regard to your current problem?

	Date	**What Area of Body/Results**
X-Rays		
Bone Scan		
MRI		
CAT Scan		
Myelogram		
EMG/NCS		
Cystoscopy		
Colonoscopy		
Epidural Steroid Injection		
Nerve Root Block		
Facet Joint Injection		
Urodynamics		
Other		

Medications:	**Type**	**Dosage**	**How long have you been on it?**

Developmental History: **Note any development delays or the need for corrective bracing as child/teenager.**

_____
_____

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Therapy History

If you have had therapy/chiro in the past, please indicate where, when, and how long you attended._____
_____

Place a check next to the type of treatment you received and how it affected your pain/problem.

	Helped	No Effect	Made Worse
Hot Packs/Ultrasound	[ ]	[ ]	[ ]
Ice/Cold Treatments	[ ]	[ ]	[ ]
Massage/Myofascial/Craniosacral	[ ]	[ ]	[ ]
Traction	[ ]	[ ]	[ ]
TENS	[ ]	[ ]	[ ]
Muscle Stimulator	[ ]	[ ]	[ ]
Chiropractic/Adjustments	[ ]	[ ]	[ ]
Acupuncture	[ ]	[ ]	[ ]
Bracing/Splinting	[ ]	[ ]	[ ]
Strengthening Exercises	[ ]	[ ]	[ ]
Flexibility Exercises/Yoga	[ ]	[ ]	[ ]

Are you currently receiving any of the aforementioned treatments now? [ ] Yes [ ] No

Personal History

Regular Exercise (what and how often) _____
Dietary Habits (caffeine, alcohol, citrus, nutrisweet, servings of fruits/vegetables, bread)
_____
Fluid Intake/Day _____
Sleep Habits (trouble falling asleep, staying asleep, reason for awakening, resting in am?)
_____

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Gender Related History:

Please provide information on any of the following that apply to you

Female Gynecological History:

Have your menstrual periods stopped? Yes No (circle one)
On hormone replacement therapy? Yes No If yes, which one?
Date of last pelvic exam: _____
Do/Did you have pain with your menstrual periods? _____
Do/Did you have pain with intercourse? _____
[] Endometriosis [] Prolapse [] Cysts [] Fibroids [] Pelvic Pain
[] Other GYN _____

Female Obstetrical History for each of your children: Please provide as much information as possible.

	Birth Date	Weight	Vaginal/Cesarean	Prolonged Pushing?	Tearing/Forceps
1.					
2.					
3.					
4.					

Males: Prostate/Testicular Problems?

_____
_____

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Please answer if Pelvic Floor Concerns

Answer any that apply to you; place additional comments in margins

	BLADDER	BOWEL
How many accidents/day: Small (less than ½ cup)	_____	_____
Large (greater than ½ cup)	_____	_____
Do you wear protection?	Y N	Y N
If yes, what type?	_____	_____
Number of changes/day?	_____	_____
How often do you use the toilet during the day?	_____	_____
Do you experience strong urges to urinate or have a BM?	Y N	Y N
If yes, how much warning time to get to the toilet?	__ Seconds	__ Seconds
	__ Minutes	__ Minutes
Do you ever leak when have a strong urge?	Y N	Y N
Do you leak with….	__ coughing	__ coughing
	__ laughing	__ laughing
	__ sneezing	__ sneezing
	__ lifting	__ lifting
	__ bending over	__ bending over
	__ sexual activity	__ sexual activity
	other_____	other _____

How many times do you get up to urinate at night? _____

Do you feel you are able to empty completely?	Y N	Y N
Do you have pain/burning with voiding?	Y N	Y N
Do you have any trouble starting your stream?	Y N	Y N
Do you dribble after urinating?	Y N	Y N

Do you ever see blood in your urine or in your bowel movements? _____
Does your urine have a noticeable color or odor? Please explain _____
Do you experience abdominal bloating or tenderness? _____
Do you have constipation or diarrhea or both? _____
Any other comments or questions that have not been addressed above?

_____
_____
_____
_____

This would be some sample text to see that it could be edited.

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