ART SANSONE · PT

INTAKE QUESTIONNAIRE

Name:_____ Date:_____

Date of Birth: _____ Email: _____ Phone: _____

Referral from: _____

Primary physician: _____

Reason for referral: _____

Date of onset: _____

What function(s) do you hope to improve/change by coming to physical therapy? What are your physical goals?

_____

_____

_____

Medical History

If you have had surgery for this or a different diagnosis, please complete the following for each:

Surgery type and date: _____ Improvement?_____

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Prior physical injury history: Include major work or non-work related injuries (fractures, major sprains/strains) and their dates:

_____

_____

_____

Please check all that apply to you:

___ Osteoarthritis
___ Rheumatoid arthritis
___ Osteoporosis/Osteopenia
___ Pregnant/attempting pregnancy
___ Heart problems/heart disease
___ Severe headaches
___ Recurrent muscle/joint pain
___ Cancer_____
___ Lyme disease/tick-related illness
___ Multiple sclerosis
___ Fibromyalgia
___ Skin condition_____
___ Allergies _____
___ Pacemaker
___ Blood pressure- High/Low
___ Poor balance or recent falls
___ Endometriosis
___ Tuberculosis
___ GERD/Heartburn
___ Chemical dependency (alcohol/drugs)
___ Bleeding disorders
___ Other_____

___ Dizziness/vertigo/fainting
___ Gastrointestinal issues (IBS, Crohn's)
___ Stroke
___ Using blood thinners
___ Hepatitis A/B/C
___ Circulation problems/blood clots
___ Diabetes Type 1/Type 2
___ Chest pain/angina
___ Kidney disease/stones
___ Bronchitis/emphysema/pneumonia
___ Thyroid condition
___ Asthma
___ Epilepsy
___ Prostate issues
___ Gout
___ Depression
___ Nerve injury
___ HIV/AIDS
___ Menstrual issues
___ Abdominal pain/bloating
___ Psychological_____

Please list any medications you are currently taking, type, dosage and how long you have been taking it:

_____

_____

_____

_____

Current Condition

Where is/are your pain/symptoms (i.e., location and type)?

_____

_____

_____

_____

When did this current episode begin? Was the onset gradual or sudden?

_____

_____

How did the episode of pain/symptoms begin? If your pain/symptoms are due to an injury, briefly describe the events leading to the injury.

_____

_____

Have you had prior episodes of the pain/problem? ___Yes ___No

If yes, how many episodes have you had? _____
When did the first episode begin?_____
Is this episode worse than the prior episode(s)? ___Yes ___No
What caused the prior episode(s)? _____

_____

Date/outcome of any medical tests/special tests performed with regard to your current issue:

X-rays: _____
MRI/CT scan: _____
EMG: _____
Steroid/Other injection: _____
Other: _____

Are you receiving any current therapy (i.e., physical therapy/chiropractic/massage/ exercise, etc.) for your current condition? If so, please indicate type and effectiveness:

_____

_____

Please check the activities below that affect your pain/problem:

	Better	Worse	No change
Standing	____	____	____
Sitting	____	____	____
Walking	____	____	____
Driving	____	____	____
Bending forward	____	____	____
Bending backward	____	____	____
Lying on stomach	____	____	____
Lying on back	____	____	____
Reaching overhead	____	____	____
Reaching behind back	____	____	____
Lifting > 5lbs	____	____	____
Pushing/Pulling > 5lbs	____	____	____
Gripping with hand	____	____	____
Writing	____	____	____
Typing	____	____	____
Using computer mouse	____	____	____
Squatting	____	____	____
Kneeling	____	____	____
Coughing	____	____	____
Sneezing	____	____	____
Sleeping	____	____	____
Other _____	____	____	____

On a 0 to 10 pain scale, with "0" being "no pain" and "10" being the "greatest level of pain":

What number represents your WORST level of pain?

0 1 2 3 4 5 6 7 8 9 10

What number represents your LEAST level of pain?

0 1 2 3 4 5 6 7 8 9 10

What number represents your level of pain AT THIS TIME?

0 1 2 3 4 5 6 7 8 9 10

Signature _____ Date _____