PT by Marge
Hands on Manual Therapy for Health and Wellness

Intake Questionnaire

Name:_____Date:_____

Phone :_____Address:_____

Email Address:_____

Date of birth:_____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?

_____

_____

_____

_____

_____

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
_____	_____	☐	☐	☐	_____
_____	_____	☐	☐	☐	_____
_____	_____	☐	☐	☐	_____

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Please check all that apply to you.

☐ Rheumatoid Arthritis	☐ High or low Blood Pressure	☐ Emphysema
☐ Congenital heart defect	☐ Bleeding disorders	☐ Pacemaker
☐ Osteoarthritis	☐ Heart problems/heart disease	☐ Tuberculosis
☐ Diabetes Type I or 2	☐ Chest pain/angina/palpitations	☐ Cancer
☐ Hepatitis A, B, C	☐ Circulation problems or blood clots	☐ Stroke
☐ Osteoporosis or Osteopenia	☐ Bronchitis/pneumonia	☐ Asthma
☐ Thyroid Condition	☐ Sexually transmitted diseases or HIV/AIDS	☐ Liver disease
☐ Using blood thinners	☐ Currently Pregnant or attempting pregnancy	☐ Toxoplasmosis
☐ Poor balance or recent falls	☐ Dizziness/vertigo/fainting/blackouts	☐ Fibromyalgia
☐ Recurrent muscle/ joint pain	☐ Chemical dependency (i.e. alcoholism or drugs)	☐ Anemia
☐ Severe headaches	☐ Lyme disease, tick related diseases	☐ Psychological
☐ Skin problems	☐ Epilepsy/seizure disorders	☐ Menopause
☐ Food intolerance	☐ Gastrointestinal issues (IBS, Crohn's)	☐ Depression
☐ Latex Allergy	☐ Abdominal pain/bloating/gas	☐ Gout
☐ Multiple sclerosis	☐ Kidney disease/stones	☐ Heartburn/GERD
☐ Other		

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

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

Allergies (please list):_____

_____

_____

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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

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

Ache: *AAA* Burning: XXX Numbness: *OOO* Pins/Needles: … Stabbing: ///

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

Regular Exercise (what and how often) _____
Sleep Habits (trouble falling asleep, staying asleep, reason for awakening, resting in am?)

_____
_____
_____
_____
_____