



**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":

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What activities make your problem worse?

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

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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
_____	_____				_____
_____	_____				_____
_____	_____				_____



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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?**

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

Allergies (please list): \_\_\_\_\_



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Medications (please list): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

## 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?)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_