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

______________ ______________ ______________

______________ ______________ ______________

______________ ______________ ______________

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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Medications (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?)

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