



INTAKE QUESTIONNAIRE

Name _____ Date _____ Phone # _____
 Address _____
 Insurance _____
 Referring MD _____ Date of Birth _____
 Occupation _____
 Reason for Referral _____

Date of Onset _____

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
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Describe your Problem _____

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

What activities make your problem worse?

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

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

Medical History

(Fill in background information on the following by checking all that apply to you)

- Arthritis
- Heart Disease
- High Blood Pressure
- Circulation Disease
- Diabetes Type I
- Diabetes Type II
- Allergies (please list) _____ Cancer
- Breathing Problems Osteoporosis
- Thyroid Condition
- Currently Pregnant or attempting pregnancy Recurrent muscle joint pain problems
- Infectious Disease (HIV, Hepatitis, etc.) Other _____



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

Table with 3 columns: Test Name, Date, What Area of Body/Results. Rows include X-Rays, Bone Scan, MRI, CAT Scan, Myelogram, EMG/NCS, Cystoscopy, Colonoscopy, Epidural Steroid Injection, Nerve Root Block, Facet Joint Injection, Urodynamics, Other.

Table with 3 columns: Medications, Type, Dosage, How long have you been on it?

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

Gender Related History: Please provide information on any of the following that apply to you

Gynecological History

Form with questions: Have your menstrual periods stopped? On hormone replacement therapy? 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

Obstetrical History for each of your children:

Please provide as much information as possible

Table with 5 columns: Birth Date, Weight, Vaginal/Cesarean, Prolonged Pushing?, Tearing/Forceps. Rows 1-4.

Males: Prostate/Testicular Problems?

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ice/Cold Treatments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Massage/Myofascial/Craniosacral Release	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Traction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
TENS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle Stimulator	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chiropractic/Adjustments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Acupuncture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bracing/Splinting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Strengthening Exercises	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Flexibility Exercises/Yoga	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

Primary Care Physician: _____ Date of last complete physical _____

Medication Allergies: _____

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 Bowel Habits
- Stiffness in Joints Swollen Ankles/Legs Depression Unexplained Weight Loss
- Black/Bloody Stool Painful Urination Anxiety Urinary Incontinence
- Joint Swelling/Warmth Difficulty Swallowing Easy Bruising Unusual Stress in Home Life
- Nodes (groin/armpit/neck) Difficulty Sleeping Unusual Stress in Work Life

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?)
- _____

Incontinence Symptoms: Please answer any that apply to you; place additional comments in margins

	<u>BLADDER</u>		<u>BOWEL</u>	
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?	Y	N	...to have a bowel movement?	
			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...	<input type="checkbox"/>	coughing	<input type="checkbox"/>	coughing
	<input type="checkbox"/>	laughing	<input type="checkbox"/>	laughing
	<input type="checkbox"/>	sneezing	<input type="checkbox"/>	sneezing
	<input type="checkbox"/>	lifting	<input type="checkbox"/>	lifting
	<input type="checkbox"/>	bending over	<input type="checkbox"/>	bending over
	<input type="checkbox"/>	sexual activity	<input type="checkbox"/>	sexual activity

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 strain to empty? 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

Do you dribble after urinating? Y N

What activities/positions precede a leak or an accident? _____

Do you ever see blood in your urine or in your bowel movments? _____

Does your urine have a noticeable color or odor? Please explain _____

When you urinate, does your urine always come out in a strong stream or does it sometimes come out dribbling?

Do you ever have hesitancy or an interrupted stream of urine? _____

Do you experience abdominal bloating or tenderness? _____

Explain your bowel habits (frequency, any laxatives, enemas, manual stimulation, etc.)

Do you alternate between constipation and diarrhea? _____

What is the consistency of your bowel movements?

Liquid Loose Well-formed Hard Small and Hard

Any other comments or questions that have not been addressed above?

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 Fall Pushing/Pulling
 Motor Vehicle Accident Other _____

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

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

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?

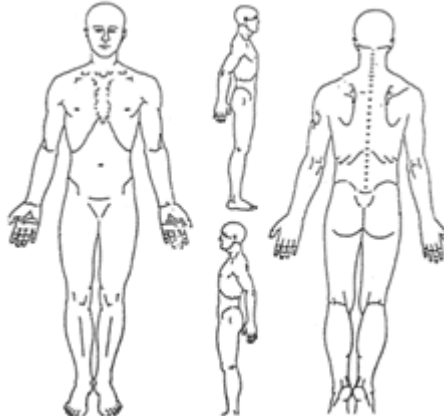
Is this episode worse than the previous episode?

Yes No

Explain what caused the prior episodes. _____

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

Ache: AAA Burning: XXX Numbness: OOO Pins/Needles: ... Stabbing: ///



Please check the activities that affect the pain/problem.

	Better	Worse	No Change		Better	Worse	No Change
Coughing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sneezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Straining	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pushing/Pulling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Driving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bending Forward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



Bending Backward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lying on Back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying on Stomach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Overhead Reaching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Squatting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kneeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Typing/Writing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Intercourse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please circle the number that best represents your *average* pain.

What is the LEAST? 0 1 2 3 4 5 6 7 8 9 10

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