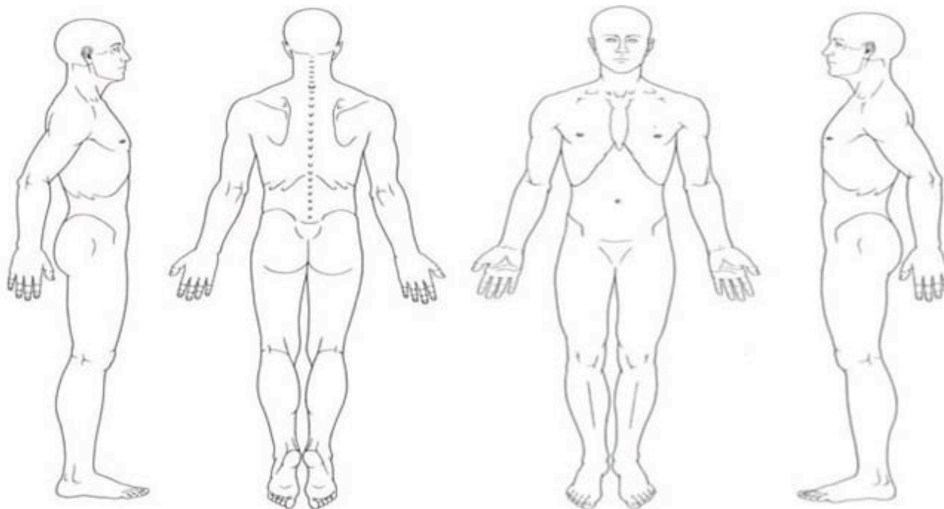
BodyDynamic

physical therapy + pilates + wellness

Physical Therapy Patient Intake Questionnaire

Patient Name_______________________________ Age_____ Date of Birth_____________ Date_________
Occupation/Work activities____ Currently Working? Yes No Modified
Sports/Hobbies____ Dr.________________________________
Hand Dominance R L Stairs @Home Y N

Please indicate your symptoms on the body chart below



How did your Problem begin? (Check all that apply)

___Sudden ___Gradually ___During Sports ___At Work
___Fall ___Auto Accident ___Hit From Behind ___Hit from Side
___Lifting ___Bending ___Pushing ___At Home
___Pulling ___Twisting ___No Apparent Cause other___________

When did your Symptoms Begin?_____________________________________
Have you had Surgery for this problem?__Yes___No When?_____________
What have you done for treatment thus far? ___Ice ___Heat ___PT
___Stretches ___Chiropractic ___Accupuncture ___Other____________
Medications____

Is your sleep disrupted? ___Yes ___No

Have you had similar Symptoms before? ____Yes ___No When? ______
What % did your symptoms resolve? _____

Please Prioritize your areas of complaint from body chart above:
1:____________________ 2.__________________ 3__________________

Please rate your pain on a scale of 0 to 10 for each area: 0 is no pain; 10 is maximum pain (go to hospital)

Area 1: Worst___ Best___ Now___ **Area2**: Worst___ Best___ Now___ **Area3**: Worst___ Best___ Now___

Physical Therapy Patient Intake Questionaire page 2 continues in columns from page 1

Please use the following columns to describe your complaints:

Area 1:__________	**Area 2**:__________	**Area 3**:____________
pain ache stiff burning	pain ache stiff burning	pain ache stiff burning
numb weak limited motion	numb weak limited motion	numb weak limited motion
tight pins & needles sharp	tight pins & needles sharp	tight pins & needles sharp

Have Your Symptoms Changed in Any Way? (circle most appropriate) In the last month 2 weeks 1 week other____

1:__Better __Worse __Same **2**:__Better __Worse __Same **3**:__Better __Worse __Same

How often do you experience your pain/symptoms?

1	2	3
constantly (100%) frequently(75%)	constantly (100%) frequently(75%)	constantly (100%) frequently(75%)
intermittantly (50%) occaisionally(25%)	intermittantly (50%) occaisionally(25%)	intermittantly(50%) occaisionally(25%)

Is your complaint affected by the time of day?

1	2	3
Worse in the morning evening	Worse in the morning evening	Worse in the morning evening
other_____________________	other_____________________	other_____________________
Better in the morning evening	Better in the morning evening	Better in the morning evening
other_____________________	other_____________________	other_____________________

What Makes Your Symptoms Worse? (Please mark with a 1, 2, 3 as appropriate)

____exercise(during)	_____Bending forward	_____pushing	_____squatting
_____exercise (after)	_____bending backward	_____pulling	_____looking up
_____sitting	_____coughing	_____reaching	_____looking down
_____standing	_____sneezing	_____driving	_____turning left
_____walking	_____stairs (up)	_____twisting	_____turning right
_____jogging	_____stairs (down)	_____uneven surfaces	_____other

What Reduces Symptoms (Please mark with a 1, 2, 3 as appropriate) Please Circle Your Most Comfortable Position

_____lying on back	_____medication	____elevation
_____lying on stomach	_____injections	_____compression (ace wrap)
_____lying on side	_____heat	_____ice
_____walking	_____exercise	_____resting
_____sitting	_____standing	_____other

What is your Health Status? Excellent Good Fair Poor

Do you currently Smoke? Yes No _____Packs/day

Please list any significant medical problems________________________________

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