Intake Questionnaire

Please fill out the following questionnaire as completely as possible.
This enables your Therapist to establish a clinical profile that is safe and appropriate for your individual needs.

Patient Name: _____ Date: _____

Occupation: _____ Work Status: _____

Allergies: _____

Please list X-rays, MRI, or other tests that were performed for this condition? _____

Previous treatments (Physical Therapy, chiropractic, injections, etc.): _____

Current Medications: _____

Do you smoke or chew tobacco? ☐ Y ☐ N How many packs a day? _____ For how long? _____

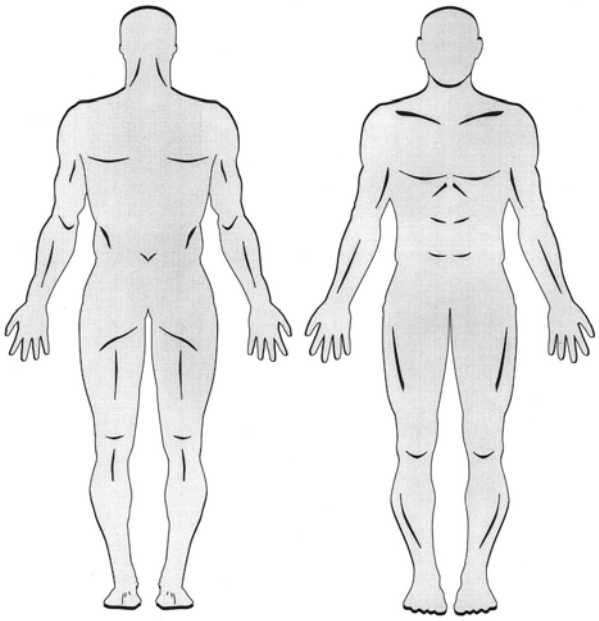
Do you drink alcoholic beverages? ☐ Y ☐ N How many drinks per week? _____

Please list hobbies/exercise and frequency? _____

Where is your pain? _____

Please use the following symbols to mark on the drawing the areas you feel pain.

Pain:
Numbness: / / /
Pins/Needles:::
Shooting:xxxx



Pain Intensity: 0 1 2 3 4 5 6 7 8 9 10

No Pain Severe Pain

How would you describe your pain?

☐ 1- Sharp	☐ 5 - Throbbing	☐ 9 - Numb
☐ 2 - Shooting	☐ 6 - Pulling	☐ 10 - Heavy
☐ 3 - Burning	☐ 7 - Ache	☐ 11 - Tight
☐ 4 - Dull	☐ 8 - Tingling	☐ 12 - Stabbing

1. Is your pain constant? ☐ Yes ☐ No If NO, How long does it last? _____

2. What alleviates your pain? ☐ Rest ☐ Walking ☐ Exercise ☐ Heat ☐ Ice ☐ Medication ☐ Other _____

3. What aggravates your pain? ☐ Lifting ☐ Walking ☐ Sitting ☐ Standing ☐ Sleeping ☐ Other _____