restore
PHYSICAL THERAPY

PATIENT INTAKE QUESTIONNAIRE

Name: _____ Date: _____

Preferred Name: _____ Referring Physician: _____

Preferred Pronouns: She/Her He/His They/Them DOB: _____ Height: _____ Weight: _____

Please describe your main problem: _____

_____

When did it begin?_____ Is it getting **(circle one)**: better / worse / staying the same

What prior treatment have you received (chiropractic, massage, etc.)? _____

_____

What makes it worse? _____

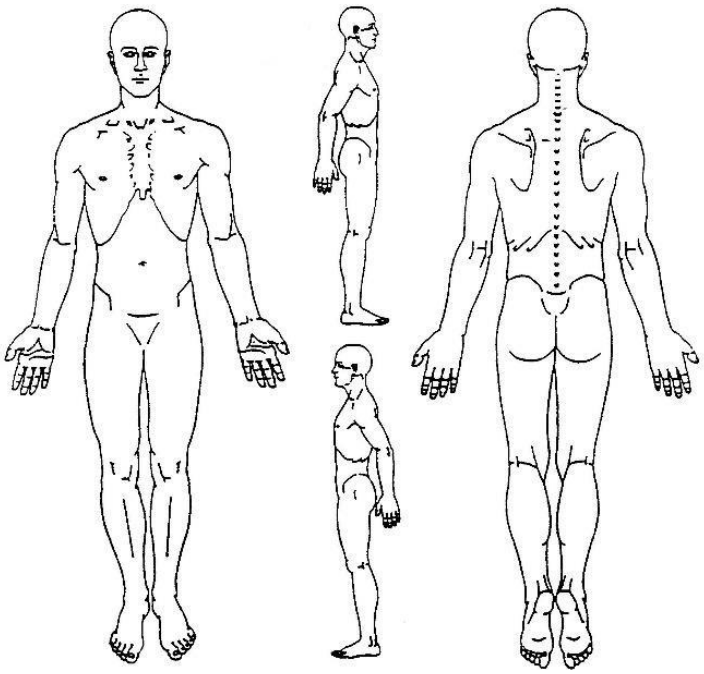
What makes it better? _____

Medical History:

Do you have or have you had the following:

	Yes	No
Cancer		
Diabetes		
Osteoarthritis		
Rheumatoid Arthritis		
Osteoporosis		
Headaches		
Ringing in Ears		
Hypoglycemia		
High Blood Pressure		
Heart Disease		
Pacemaker		
Lung Disease		
Neurological Condition (MS, Parkinson's, CVA/Stroke)		
Thyroid Condition		
Dizziness/Fainting		
Fevers/Chills		
Unexplained Weight Changes		
Bowel/Bladder Issues		
Urine Leakage		
Pelvic Pain		
Other Conditions		

Please indicate below where your symptoms are located:



KEY: numbness: ====
pins & needles: 0000
stabbing pain: / / / /
burning pain: XXXX

Pain level (0-10, 0=no pain, 10=worst pain):
Current: ____ / 10
At best: ____ / 10
At worst: ____ / 10

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If you answered yes to any of the above, please explain:

_____

_____

Do you have any allergies? Y / N
Please explain: _____

_____

Surgical History:

Spine:	Y / N	Date: _____	Hysterectomy:	Y / N	Date: _____
Shoulder:	Y / N	Date: _____	C-Section:	Y / N	Date: _____
Knee:	Y / N	Date: _____	Prostatectomy:	Y / N	Date: _____
Hip:	Y / N	Date: _____	Appendectomy:	Y / N	Date: _____
Ankle:	Y / N	Date: _____	Gall Bladder:	Y / N	Date: _____
Laparoscopy:	Y / N	Date: _____	Hernia repair:	Y / N	Date: _____

Other surgeries: _____ Any upcoming surgeries/procedures? Y / N

_____ _____

Are you currently taking any medication/supplements (prescription or over-the-counter)? Yes____ No____
If yes, please list medications:

Medication name: **Dosage/ frequency** **Route (i.e.: oral, cream)**

_____

_____

_____

_____

_____

_____

_____

Have you had any falls in the past 12 months? (circle one) Yes / No
If yes, how many? _____ Were you injured in the fall(s)? (circle one) Yes / No

What activities/exercise do you currently participate in? (running, swimming, yoga, golf, etc)

_____

_____

Which activities or tasks would you like to be able to perform that you can't currently do because of your current concern?

_____

_____

_____

Any additional comments or concerns not addressed in this questionnaire?

_____

_____