PT NORTHWEST

Patient Intake Questionnaire

Name_____ Date_____

DOB_____ Age:_____ Gender: M F Non-Binary

Referring MD_____ Primary MD (If different)_____

How did you hear about our clinic? (Doctor, other patient, advertising…)_____

Occupation?_____ Are you currently working? Yes No

If you are **NOT** working, what was your **last day of work**?_____

Date of injury/accident/onset of symptoms:_____ Date of surgery:_____

Briefly describe the problem you are here for and how it started:_____

_____

_____ Symptoms appeared: Gradually Suddenly

Feelings of: Pain Swelling Weakness Numbness If pain: Local (or radiates into) Arm Leg

Describe your pain: Aching Burning Dull Sharp Other:_____

Where is it located?_____

Similar problem on other occasions? Yes No Most recent was, when?_____

Does the pain wake you at night? Yes No If yes, can you get back to sleep? Yes No

What, if anything, can you do to make your symptoms **DECREASE**?_____

What, if anything, makes your symptoms **WORSE**?_____

Have you had any of the following **TESTS** for **THIS** problem? MRI Ultrasound CT Scan X-Ray

Bone Scan Arthrogram Other:_____

What, if known, are the results of the above tests?_____

Please list any surgeries, injuries for which you have been treated, or other conditions for which you have been hospitalized:

INJURY	SURGERY	HOSPITALIZATION	REASON	DATE
❑	❑	❑		
❑	❑	❑		
❑	❑	❑		
❑	❑	❑		
❑	❑	❑		

If surgery; recovery has been: Full Partial Not at all

(Continued on back

PT NORTHWEST

Indicate which of the following conditions **YOU** (or ANYONE IN YOUR IMMEDIATE FAMILY) have **EVER** been diagnosed as having or have at the present:

YOU	FAMILY MEMBER		YOU	FAMILY MEMBER	
❑	❑	Anemia	❑	❑	Gastritis/ulcers
❑	❑	Asthma/Emphysema/Bronchitis	❑	❑	Heart (surgery, attack, disease)
❑	❑	Arthritis: Osteo, Rheumatoid	❑	❑	High blood pressure
❑	❑	AIDS/HIV positive	❑	❑	Hepatitis: A B C D
❑	❑	Artificial joints (hip, knee, etc.)	❑	❑	Hemophilia
❑	❑	Anxiety attacks	❑	❑	Hysterectomy
❑	❑	Bruise easily	❑	❑	Incontinence
❑	❑	Chronic cough	❑	❑	Kidney disease
❑	❑	Cancer (If YES, describe what type:) _____	❑	❑	Liver disease
			❑	❑	Multiple Sclerosis
❑	❑	Cardiac pacemaker	❑	❑	Nursing your child
❑	❑	Cortisone medication/steroids *(eg. Prednisone, Dexamethasone)*	❑	❑	Osteoporosis
			❑	❑	Pregnant ❑ Presently
❑	❑	Chest pain	❑	❑	Psychiatric care
❑	❑	Diabetes: Type 1 Type 2	❑	❑	Stroke
❑	❑	Depression	❑	❑	Shortness of breath
❑	❑	Drug or alcohol dependency	❑	❑	Thyroid problems
❑	❑	Epilepsy or seizures	❑	❑	Tuberculosis
❑	❑	Fainting/dizziness			
❑	❑	Other disorder(s) not listed above: _____			

List any PRESCRIPTION medication you are **currently** taking (Including: pills, injections, skin patches): _____

Which of the following OVER THE COUNTER medications have you taken in the last week?

- ❑ Advil/Motrin/Ibuprofen
- ❑ Aleve
- ❑ Alternative Medicines
- ❑ Antacids
- ❑ Antihistamines
- ❑ Aspirin
- ❑ Decongestants
- ❑ Tylenol
- ❑ Laxatives
- ❑ Vitamins/Mineral Supplements
- ❑ Other: _____

Please list known ALLERGIES:

- ❑ Latex
- ❑ Tape/Adhesive
- ❑ Other Skin Allergies
- ❑ Medications: _____
- ❑ Other: _____

Are you currently receiving or have you received Home Health Services (including any therapy, nursing, bathing and dressing, etc) in the last 60 days? Yes No

Are you currently receiving, or have you received other therapy services in the last 60 days? Yes No

List any prior treatment you have received for THIS problem (ie, Physical/Occupational Therapy, Chiropractic, Acupuncture, Massage):

Was the treatment successful? Yes No

Are you a smoker? Yes No If yes, how many packs, on average, do you smoke per day? _____

Do you consume alcohol? Yes No If yes, how many drinks per day? _____ Per week? _____

What do YOU wish to achieve with physical therapy? (YOUR PERSONAL GOAL(S)): _____

PATIENT SIGNATURE: _____ REVIEWED by Therapist: _____ Date _____