

## Rehabilitation Pre-Operative Intake Questionnaire







Today's Date \_\_\_/\_\_\_/\_\_\_ Name \_\_\_\_\_  
Date of Birth \_\_\_/\_\_\_/\_\_\_ Age \_\_\_ Weight \_\_\_ Height \_\_\_ Dominant Hand  R  L  
Physician who sent you here \_\_\_\_\_ Primary Care Physician \_\_\_\_\_  
Next scheduled physician appointment \_\_\_/\_\_\_/\_\_\_  
Anticipated Surgical Procedure \_\_\_/\_\_\_/\_\_\_ Scheduled Surgery Date \_\_\_/\_\_\_/\_\_\_

### WORK HISTORY

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Presently Working?  Yes  No  
If yes, any restrictions? \_\_\_\_\_ If not working, since when? \_\_\_/\_\_\_/\_\_\_ Return to work date \_\_\_/\_\_\_/\_\_\_  
Are you returning to the same job?  Yes  No Same Employer?  Yes  No \_\_\_\_\_

**DISCOMFORT SCALE** Please indicate your current pain level below

0---1---2---3---4---5---6---7---8---9---10

No Pain	Moderate Pain	Worst Pain						
			0 NO HURT	1 HURTS A LITTLE BIT	2 HURTS A LITTLE MORE	3 HURTS EVEN MORE	4 HURTS A WHOLE LOT	5 HURTS WORST

Describe discomfort:  Sharp  Aching  Dull  Burning  Tingling  Numbness

### DIAGNOSTIC TESTS

What tests were done?  None  X-rays  MRI  CT Scan  Bone Scan  EMG  Doppler/US  
What were the results? \_\_\_\_\_ Where was it done? \_\_\_\_\_

### SOCIAL HISTORY

Do you live alone?  Yes  No If no, with whom? \_\_\_\_\_  
Do you require assistance from someone for daily activities?  Yes  No  
Do you receive the following:  Home Health Aide/Nurse  Meals on Wheels  Other: \_\_\_\_\_  
How do you learn the best?  Seeing  Hearing  Doing  
Any barriers to learning?  Vision Impaired  Hearing Impaired  Memory Problem  None  
Other concerns we need to know to better serve you? \_\_\_\_\_

### MEDICAL HISTORY

Have you ever had similar problems in the past?  Yes  No When? \_\_\_\_\_  
Have you received or are you receiving other treatment from any of the following? (check all the apply):  None  
 Massotherapy  Chiropractor  Acupuncturist  Psychologist  Specialty Physician  Previous PT  
When? \_\_\_/\_\_\_/\_\_\_  
Previous fractures? (where and when) \_\_\_\_\_

