

Rehabilitation 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 _____

WORK HISTORY

Employer _____ Occupation _____ Presently Working? [] Y [] N
If yes, any restrictions? _____ If not working, since when? ____ / ____ / ____ Return to work date ____ / ____ / ____
Are you returning to the same job? [] Y [] N Same employer? [] Y [] N _____
Briefly describe your job: _____

HISTORY

What is your physical complaint? _____

When did the symptoms start? ____ / ____ / ____

Was there a specific incident that brought on your pain? [] Y [] N Explain _____

Were you hospitalized or did you have surgery for this problem? [] Y [] N Date admitted ____ / ____ / ____

How long? _____ What was the surgical procedure? _____ Surgery Date ____ / ____ / ____

DISCOMFORT SCALE

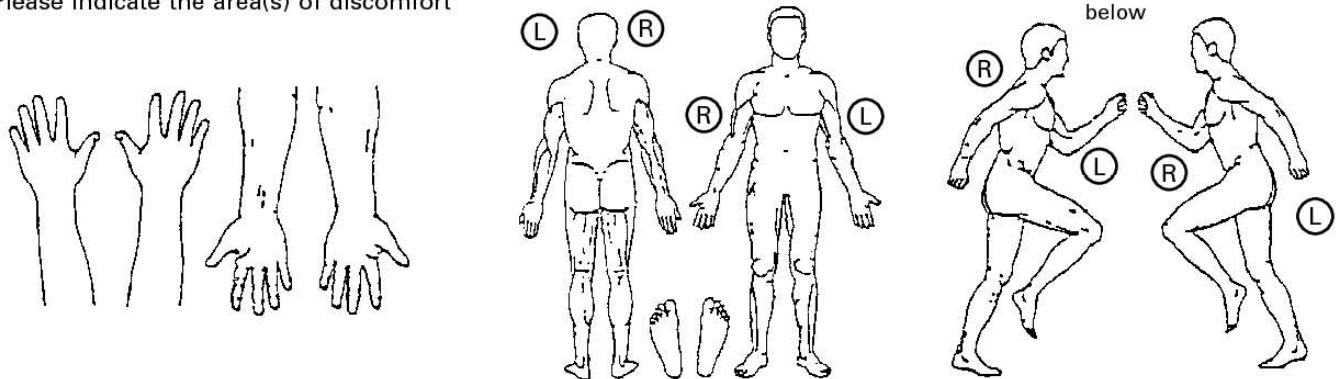
Please indicate your current pain level below

0 --- 1 --- 2 --- 3 --- 4 --- 5 --- 6 --- 7 --- 8 --- 9 --- 10
No Pain Moderate Pain Worst Pain



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

Please indicate the area(s) of discomfort



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? [] Y [] N If no, with whom? _____

Do you require assistance from someone for daily activities? [] Y [] N

Do you receive the following: [] Home Health Aide / Nurse [] Meals on Wheels [] Other: _____

Are you responsible for the physical care of another individual at home? [] Y [] N Whom? _____

Does your home have any of the following? [] Ramp [] Stairs / steps # ____ [] Rails (1 or 2)

How do you learn 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? Y N When? _____

Have you received or are you receiving other treatments from any of the following? (check all that apply): None

Massotherapist Chiropractor Acupuncturist Psychologist Specialty Physician Previous PT

When: ____ / ____ / ____

Previous fractures? (where and when?) _____

Previous **surgeries**? (where and when?) _____

Medical History: Do you have or have you had any of these medical conditions: (please circle Y or N)

- | | | | |
|-----|--|-----|--|
| Y N | Currently Pregnant | Y N | Lung Problems |
| Y N | Changes in bowel / bladder habits | Y N | Diabetes: <input type="checkbox"/> Type I <input type="checkbox"/> Type II |
| Y N | Unexplained weight loss / gain | Y N | Ringing in your ears |
| Y N | Fever / Chills / Sweats within last 3 months | Y N | Thyroid problem |
| Y N | Fatigue | Y N | Difficulty walking |
| Y N | Dizziness / lightheadedness | Y N | Balance problems / falls |
| Y N | Recent Nausea / Vomiting | Y N | Seizures / Epilepsy |
| Y N | Pain that interrupts your sleep | Y N | Rheumatoid Arthritis |
| Y N | Heart Problems | Y N | Stroke |
| Y N | Pacemaker | Y N | Osteoporosis |
| Y N | High Blood Pressure | Y N | Osteoarthritis |
| Y N | Swallowing / speech difficulty | Y N | Asthma |
| Y N | Fibromyalgia | Y N | Cancer: Type _____ |
| Y N | Kidney Disease | Y N | Is the cancer in remission? |
| Y N | Psychological disorders _____ | Y N | Are you receiving Cancer treatment? |

Allergies: Do you have allergies to any of the following: (please circle Y or N and describe any reactions)

- | | | |
|-----|-------------------------------|----------|
| | | Reaction |
| Y N | Latex | _____ |
| Y N | Adhesive tape | _____ |
| Y N | Wool | _____ |
| Y N | Chlorine based pool chemicals | _____ |
| Y N | Foods: Please specify _____ | _____ |
| Y N | Beeswax | _____ |
| Y N | Medications: list _____ | _____ |
| Y N | Other _____ | _____ |

Activity Level:

On the left side of the chart, please use the following scale (1-4) to rate your ability to perform these activities:

1 = Unable 2 = Able with assistance 3 = Able by myself with increased effort or pain 4 = Able without difficulty

Rate your Self Care Skills			Tolerances	
Skills	Current ability to perform activities	Prior to this present problem / diagnosis	How long can you tolerate the following?	
Personal Hygiene			Sitting	Minutes
Dressing			Standing	Minutes
Bathing / Showering			Walking	Minutes
Grooming			Stooping	Minutes
Meal Preparation			Squatting	Minutes
Bed Mobility			Steps How many?	
Changing Positions			Lift/Carry - How Much?	Pounds
Reaching overhead/shoulder level				
Reaching waist level				
Walking				
Ascend/descend Stairs				
Stooping over				
Lifting / Carrying				
Squatting				

What are your goals for physical / occupational therapy?

Information provided by: Self Guardian / Parent Spouse Other: _____

Signature

Reviewed by Therapist