FAST PHYSICAL THERAPY

Patient Intake Questionnaire

Date: ______________

Patient's Name: ____

Date of Birth: __________________ Age: _______ Sex: __________________

About your current complaint…

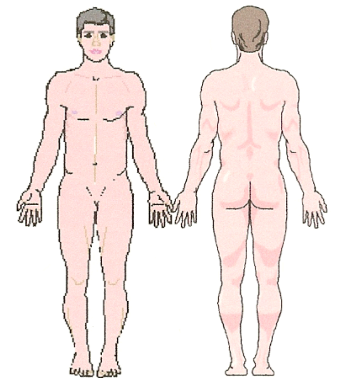
1. What is the complaint that brought you here? ____
2. When did this complaint begin, or recently become worse? Approximate Date: ______________________
3. What caused this complaint? ____
4. Does this complaint affect your activity choice, tolerance, efficiency or effectiveness? □ Yes □ No

   If "Yes", what activities? ____

5. What makes this complaint better? ____

   Worse?____

6. Does this complaint affect your comfort, mood or ability to sleep? □ Yes □ No
7. What symptoms are you experiencing with this complaint?
   □ Swelling □ Loss of balance or coordination
   □ Loss of motion □ Numbness □ Pain: Draw pain areas on body diagrams…
   □ Weakness □ Tingling
   □ Other (Specify) ____



8. How frequent are the symptoms experienced? □ Constant □ Intermittant
9. How much pain are you experiencing?
   □ None □ Very Mild □ Mild □ Moderate □ Severe □ Very Severe
10. What tests have you had for this complaint?
    □ XRay □ CAT Scan □ MRI □ Myelogram □ Bone Scan
11. What treatment have you had for this complaint? □ Physical Therapy □ Occupational Therapy
    □ Athletic Training □ Chiropratic □ Alternative Medicine – (specify): ________________________

12. Is this complaint work related? □ Yes □ No
    If "Yes", your employer's name: ______________________________

    Your Occupation: ______________________________

    Work Status: □ Full Time □ Part Time □ Working □ Medical Restrictions □ Medical Leave

    Last Date Worked: ____________

13. Is this complaint auto related? □ Yes □ No

About your general health…

14. Please check all medical conditions that you have, or have had.
    □ Arthritis □ Heart Disease □ Stomach Disorder □ Thyroid Problems □ Panic Attack
    □ Cancer □ High Blood Pressure □ Pace Maker □ Anxiety
    □ Diabetes □ Lung Disease □ Lung Disease □ Depression
    □ Other: ______________________________

15. Please check all of the following items that currently apply to you.
    □ Hearing Problems □ Learning problems □ Bowel or bladder control
    □ Visual Problems □ Pregnant □ Smoke

16 Please list surgeries:

____
____
____

17 Please list allergies:

____
____
____

18 Please list medications you are currently taking?

____
____
____

19 Are you currently receiving psychosocial services? □ Yes □ No
    Do you want us to help you find a source for psychosocial services? □ Yes □ No

20 What goals do you want to achieve through treatment?

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