Patient Intake Health Questionnaire

Joint Ventures℠ Physical Therapy and Fitness

PATIENT NAME: _____

Have you received any health services at home? ☐ **Yes** ☐ **No**

Please describe your current complaint and functional limitations. _____

_____

What is your goal for therapy? _____

When did your problem begin? _____/_____/_____ or _____ days ago, _____ months ago, _____ years ago.

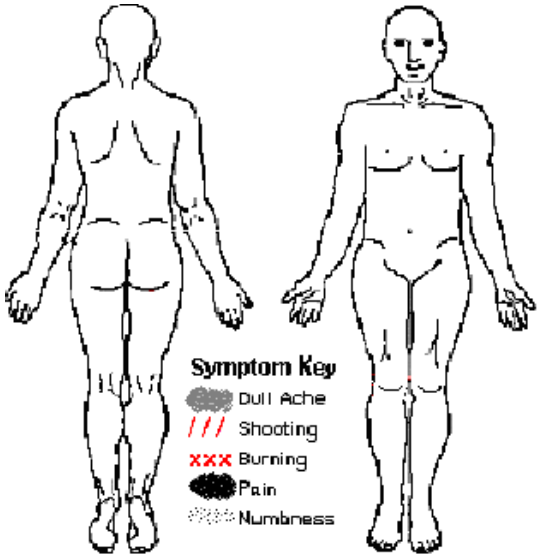
How did your problem begin? _____

Have you had recent surgery? ☐ Yes, ☐ No Date: _____/_____/_____

Please describe the nature of your pain.

- ☐ Sharp Pain
- ☐ Dull Pain/Ache
- ☐ Throbbing
- ☐ Numbness
- ☐ Shooting
- ☐ Burning
- ☐ Tingling
- ☐ Constant (76 – 100%)
- ☐ Frequent (51 – 75%)
- ☐ Occasional (26 – 50%)
- ☐ Intermittent (25% or less)
- ☐ Other: _____

Using the Symptom Key, please mark the picture where you have pain or other symptoms: ➔ ➔ ➔



Indicate the intensity of your pain at rest:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable Pain

Indicate the intensity with movement:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable Pain

Have your symptoms been: ☐ Increasing, ☐ Decreasing, or ☐ Not changing

When are your symptoms worse? ☐ Morning ☐ Afternoon ☐ Night, ☐ As the day goes on ☐ Same all day

What makes your problem better? _____

What makes your problem worse? _____

In the past have you been treated for the same problem? ☐ Yes ☐ No

Are you now being treated, or have you seen anyone for this condition? ☐ Yes ☐ No Who?: _____

What has helped? _____

Your Occupation? _____ ☐ F/T ☐ P/T Has your work status changed because of this condition ☐ Yes ☐ No

If you have ever had an injury or a medical condition in the PAST, please check it in the past column. If you are presently troubled by an injury or a medical condition, please check it in the PRESENT column. The information you provide concerning past and present conditions and diseases assist your therapist in more thoroughly understanding your state of health.

PAST	PRESENT	
☐	☐	High blood pressure
☐	☐	Heart Attack
☐	☐	Angina/ Chest pain/ Heart palpitations
☐	☐	Heart disease:_____
☐	☐	Stroke
☐	☐	Diabetes
☐	☐	Cancer or Tumors:_____
☐	☐	Respiratory or Lung Conditions
☐	☐	Shortness of Breath
☐	☐	Asthma
☐	☐	Allergies:_____
☐	☐	Tuberculosis
☐	☐	Hepatitis
☐	☐	HIV/AIDS
☐	☐	Seizures / Epilepsy
☐	☐	Chronic headaches or Migraines
☐	☐	Herpes simplex
☐	☐	Phlebitis/Thrombosis
☐	☐	Skin diseases:_____
☐	☐	Contagious disease:_____
☐	☐	Pregnancy, # ___ Caesarian? Y N
☐	☐	Surgery:_____
☐	☐	Trauma:_____
☐	☐	Fractures:_____
☐	☐	History of abuse

PAST	PRESENT	
☐	☐	Arthritis
☐	☐	Osteoporosis
☐	☐	Orthopedic Injuries:_____
☐	☐	Kidney or Liver Disease
☐	☐	Skin Conditions:_____
☐	☐	Other Hospitalization:_____
☐	☐	Drug or alcohol dependence
☐	☐	Anxiety
☐	☐	Depression
☐	☐	Pain at Night
☐	☐	Incontinence/ Bowel or bladder problems
☐	☐	Recent weight loss / Gain
☐	☐	Coordination Problems / Falls
☐	☐	Head Injury

Other Hospitalization or Surgical procedures:_____

_____

_____

Medications and what they treat: _____

_____

_____

Do you have a regular exercise program? ☐ Yes, ☐ No

Please describe: _____

Patient Signature: _____ Date: _____