UNIVERSITY ORTHOPAEDICS
PHYSICAL THERAPY

Intake Screening Questionnaire

Name: _____ SSN: _____ Date: _____

Age: _____yrs. Male ☐ Female ☐ Right handed ☐ Left handed ☐ Height: _____ Weight: _____lbs

Occupation/regular daily activity: _____

Are you **currently** or have you **recently** experienced any of the following (check all that apply)?

- ☐ Abdominal pulse
- ☐ Balance problems/falls/dizziness
- ☐ Changes in bowel or urinary function
- ☐ Confusion
- ☐ Difficulty swallowing
- ☐ Fainting/Loss of Consciousness
- ☐ Fatigue
- ☐ Fever/chills/night sweats
- ☐ Headaches
- ☐ Heartburn/Indigestion
- ☐ Feeling poorly/Lethargic
- ☐ Muscle weakness
- ☐ Nausea/vomiting
- ☐ Numbness or tingling
- ☐ Pregnancy
- ☐ Persistent Cough
- ☐ Shortness of breath
- ☐ Unexplained weight loss/gain

Have you **been told you have, experienced or been diagnosed** with any of the following (check all that apply)?

- ☐ Anemia
- ☐ Blood disorder (Hemohilia, Leukemia, Sickle Cell Disease, Clotting, Leukemia)
- ☐ Pulmorary/breathing problem (Asthma, Emphysema, COPD)
- ☐ Cancer (Chemo, Radiation, Surgery)
- ☐ Infectious Disease (HIV/AIDS, STD, Pneumonia, TB)
- ☐ Heart Disease/Attack/Failure
- ☐ Diabetes
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Peripheral Vascular Disease
- ☐ Stroke/TIA
- ☐ Depression
- ☐ Difficulty falling asleep
- ☐ Feeling tired in the AM
- ☐ Epilepsy/Seizures
- ☐ Joint Problems (Gout, RA, Lupus, Swelling)
- ☐ Osteoarthritis
- ☐ Osteopenia/Osteoporosis
- ☐ Difficult bowel movement
- ☐ Hepatitis/Liver Disease
- ☐ Difficulty in urination
- ☐ Kidney stones or infection
- ☐ Uterine/Ovarian problems
- ☐ Prostate problems
- ☐ Other: _____

During the past month have you been feeling down, depressed or hopeless? YES☐ NO☐
During the past month have you been bothered by having little interest or pleasure in doing things? YES☐ NO☐
Is this something with which you would like help? YES☐ YES, but not today☐ NO☐

Why are you here today? _____
Date of injury/onset of symptoms: _____
Did you have surgery for your current problem? YES☐ NO☐
If so, specify type or surgery: _____ Date of surgery: _____
If not, is surgery an option? YES☐ NO☐
If you had surgery, have you been using (check all that apply):
Ice☐ Heat☐ CPM☐ Rest☐ Exercise☐ Sling☐ Brace☐ Walking with crutches, acane or walker☐

List of previous surgeries*:

Type	Date (month and year)	Outcome/Complication

*If additional space is needed please use the back of page 4 to continue your list

Do you have any of the following (check all that apply)?

☐ Pacemaker ☐ Heat sensitivity ☐ Adhesive allergies
☐ Implants ☐ Cold sensitivity ☐ Other allergies/sensitivities
☐ Latex allergy ☐ Drug allergy

Have you previously been treated for this or a similar problem? YES☐ NO☐
If so, please specify type of treatment: Medication☐ Physical Therapy☐ Chiropractic☐ Alternative medicine☐
What were the treatment dates? _____

Do you have or have you in the past (check all that apply)?

☐ Smoke or use tabacco (type_____, packs_____, years_____) ☐ Drink alcoholic beverages (_____/day)
☐ Use recreational drugs ☐ Drink caffeinated beverages (_____/day)

Did you have any of the following imaging/tests performed for your current problem?
☐ X-rays ☐ MRI ☐ CT/bone scan ☐ Sonogram ☐ NCV/EMG Other: _____
Results: _____

Describe your regular exercise program, if applicable:

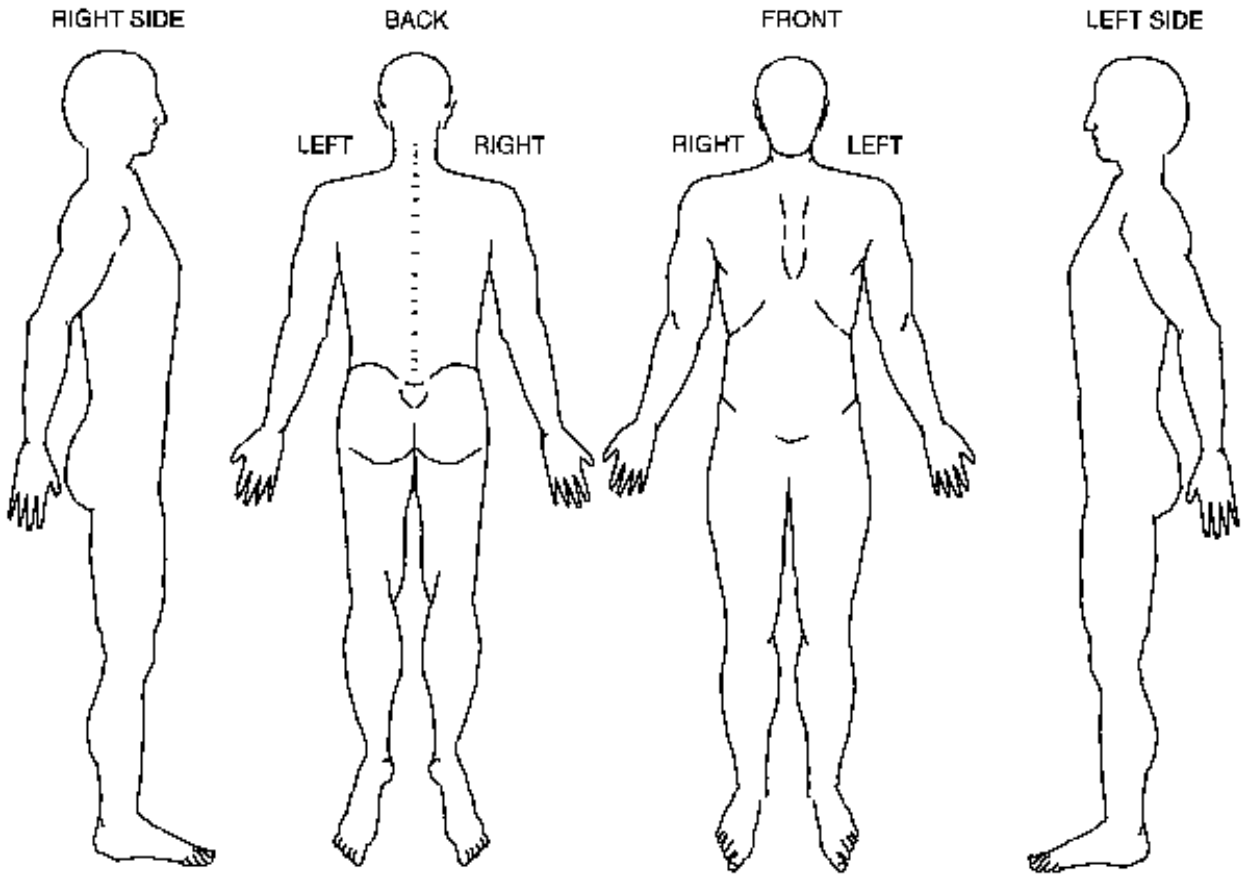
Exercise activity	Frequency

Have you been given and completed a problem-specific functional or disability questionnaire today? YES☐ NO☐
Patient-Specific Functional Scale: Identify and list (3) important activities that you are unable to do or with which you are having difficulty as a result of your current problem. Then rate your ability to perform these from 0 to 10 (0 = Unable to perform the activity; 10 = Able to perform activity at the same level as before injury)

Activity	Rating

Please mark the body chart below indicating where your symtoms occur and the sensations you feel using the key provided.

Key
//sharp or stabbing -- dull or aching XX burning
** numbness ## tingling



On the line provided, label your pain status at its current (C), best (B) and worst (W) levels in the last 48 hours:
No pain Worst Pain
>_____<

Did your symtoms begin: gradually☐ suddenly☐ ?
Did your symptoms begin from an injury: at work☐ from sports☐ a motor vehicle accident☐ other☐
Briefly describe how your injury occurred: _____

For patients with work related injury:
Are you currently working? YES☐ NO☐ If NO, date last worked: _____
If yes, do you have restrictions: YES☐ NO☐
Are you planning to: (Check all that apply)
☐Return to the same job
☐Return to a modified job with the same employer
☐Find a new job with a different employer
☐Retrain or return to school
☐Apply for early retirement or long-term disability benefits

Are your symptoms (check all that apply)?

☐ Worsening	☐ Improving	☐ Unchanged	☐ Present at hight
Worse in:			
☐ Morning	☐ Afternoon	☐ Evening	☐ After activity
Better in:			
☐ Morning	☐ Afternoon	☐ Evening	☐ After activity

What specific activities or positions ease your symtoms? _____

Which activites make your symptoms worse (check all that apply)?

☐ Sitting
☐ Rising from sitting
☐ Standing
☐ Repetitive movement
☐ Walking
☐ Running
☐ Walking up stairs
☐ Walking down stairs
☐ Laying on: affected side ☐ stomach ☐ back ☐
☐ Reaching: overhead ☐ back ☐ across ☐ sideways ☐
☐ Bending: in any direction ☐ forward ☐ backward ☐
☐ Lifting
☐ Twisting
☐ Turning in bed
☐ Caughing, sneezing, or taking a deep breath?

How long can you perform the worst of these activities before symptoms begin? _____ minutes
After your symptoms begin, how long can you continue to perform this activity? _____ minutes
After you have stopped this activity, how long do your symptoms linger? _____ minutes

Do you have any barriers to learning that would limit your ability to participate in physical therapy? If so, list:

_____

What is your personal goal for therapy? _____

Is there anything more that was not covered regarding your health or current injury that you wish to let us know about? _____

_____

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Current Medication List

Patient Name: _____ DOB: _____ Date: _____

*Please Include ALL prescriptions, over the counter medications, herbals, and vitamin/mineral/dietary nutritional supplements.

Medication Name	Dosage (25mg, etc.)	Frequency (3 x per day, etc.)	Route of Administration (by mouth, etc)