



PATIENT INFORMATION

Andrea Wolkenberg
PT, MA, CKTI

Please fill out this form by printing legibly. Today's Date: _____

Name: _____ Birth Date: _____

Gender: MALE FEMALE Height: _____ Weight: _____

Relationship Status: SINGLE MARRIED DIVORCED WIDOWED DOMESTIC PARTNERSHIP

Emergency Contact: _____
NAME PHONE

Relationship to Patient: _____
(SPOUSE/PARENT/FRIEND, ETC.)

Home Address: _____

Phone: _____
HOME CELL WORK

E-mails: _____
HOME WORK

Business Name: _____
OCCUPATION

BUSINESS ADDRESS

Primary Care Physician: _____
NAME PHONE NUMBER

PHYSICIAN'S ADDRESS

Who referred you/How did you find us? _____



PATIENT INTAKE QUESTIONNAIRE

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Name: _____

Please describe your chief complaint, and list your symptoms:

Date of Onset: _____ Have symptoms gotten better or worse over time?

Place a mark on the graphs indicating the level of pain you most frequently experience:
"0" denotes the absence of pain and "10" denotes unbearable and incapacitating pain.

During Rest: 0 _____ 5 _____ 10

During Activity: 0 _____ 5 _____ 10

Is this your first episode? Yes If no, please describe briefly your first episode and any subsequent episodes which have occurred prior to the most recent.

Have you been treated elsewhere for your current condition? Yes No

Where? _____ By Whom? _____

Was treatment successful? Yes No

Describe your pain: Sharp Dull Aching Burning Stabbing Radiating

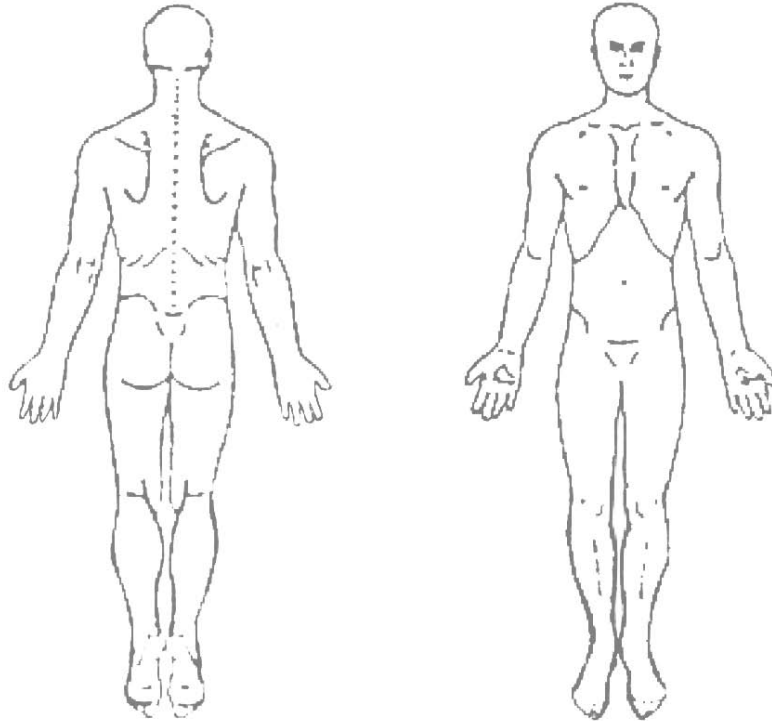
Continuous Intermittent Other _____

PATIENT INTAKE QUESTIONNAIRE – 2

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Name: _____

Please place marks on the figure below to indicate the location of your symptoms.



1. Does pain keep you from falling asleep at night? Yes No
2. Does pain wake you up at night? Yes No
3. What makes the pain better? Standing Walking Sitting
 Lying down Medication Other _____
4. What makes the pain worse? Standing Walking Sitting
 Lying down Driving Reaching up Bending forward
 Other _____
5. Does your condition prevent you from engaging in normal activities? Yes No
Which activities? _____
6. Have you lost work as a result of your current condition? Yes No

PATIENT INTAKE QUESTIONNAIRE – 3

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Name: _____

7. Do you have a litigation planned or pending regarding this injury? Yes No

8. Are you currently under the care of a physician for any medical condition? No

If yes, please describe: _____

9. Do you have a pacemaker? Yes No

10. Are you taking any medications? No If yes, please list: _____

11. Have you had any surgeries? No If yes, please list the surgery and the year: _____

12. Do you smoke? No If yes, how many packs per day? _____

13. Do you consume alcohol? No If yes, how many drinks per week? _____

14. Do you exercise regularly? No If yes, how many times per week? _____

15. Do you suffer from any of the following?

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Muscle Cramps | <input type="checkbox"/> Boils | <input type="checkbox"/> Unexplained Weight Loss |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Palpitations | <input type="checkbox"/> Difficulty Walking | <input type="checkbox"/> Unexplained Weight Gain |
| <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Uncoordinated Hand or Leg Movement | <input type="checkbox"/> Bowel or Bladder Irregularities |
| <input type="checkbox"/> Hand Tremors | <input type="checkbox"/> Nausea | <input type="checkbox"/> Difficulty Swallowing | <input type="checkbox"/> Unexplained Lumps |
| <input type="checkbox"/> Arm Weakness | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Swelling of Arms or Legs |
| <input type="checkbox"/> Leg Weakness | <input type="checkbox"/> Sleep Disturbance | <input type="checkbox"/> Tingling in Hands or Feet | <input type="checkbox"/> Drop Attacks (Fainting) |
| <input type="checkbox"/> Poor Balance | <input type="checkbox"/> Excessive Fatigue | <input type="checkbox"/> Generalized Weakness | <input type="checkbox"/> Allergies (list below) |
| <input type="checkbox"/> Unsteady Gait | <input type="checkbox"/> Double Vision | | |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Fever | | |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Chills | | |
| <input type="checkbox"/> Joint Pain | <input type="checkbox"/> Skin Rash | | |

List Allergies: _____

PATIENT INTAKE QUESTIONNAIRE – 4

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Name: _____

16. Have you ever been diagnosed with any of the following:

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Bowel/Bladder Disease | <input type="checkbox"/> Spondylolisthesis | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Spinal Stenosis | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Vascular Disease | <input type="checkbox"/> Gout | <input type="checkbox"/> Disc Herniation/Bulge | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Spinal Fracture | <input type="checkbox"/> Sleep Disorder |
| <input type="checkbox"/> Neuropathy | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Carpal Tunnel Syndrome | <input type="checkbox"/> Aneurysm |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Nerve Entrapment | <input type="checkbox"/> Blood Borne Infection (HIV/AIDS, Hepatitis, etc.) |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Thoracic Outlet Syndrome | <input type="checkbox"/> Lyme's Disease |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Ankylosing Spondylitis | <input type="checkbox"/> Reflex Sympathetic Dystrophy | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Lupus | | | |

17. How would you describe your general health?

- Excellent Good Fair Poor

18. Are you currently under an unusual amount of stress? Yes No

Describe: _____

19. Do you like your job? Yes No

20. What does your work entail? Bending Lifting Repetitive Motion

Long hours of the following: Walking Standing Sitting Computer Use
 Telephone Use

21. What is your goal/what would you like to achieve in your treatment?

- Pain Relief Resume Normal Activities Become More Physically Active
 Improve my Posture Avoid Re-Injury Other _____

Please add anything that you feel would be helpful in assessing and treating your condition.

Signature: _____ Date: _____

PATIENT OR GUARDIAN