Patient Information

Andrea Wolkenberg
PT, MA, CKTI, MCMT

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: _____
NAME

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? _____

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Patient Intake Questionnaire – 1 of 4

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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 _____

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Patient Intake Questionnaire – 2 of 4

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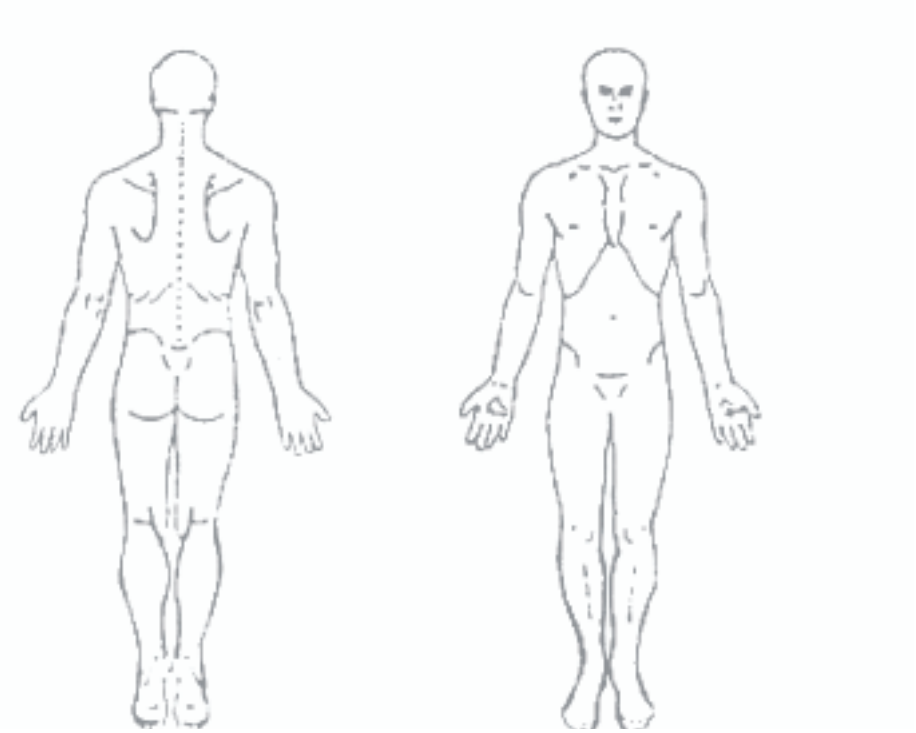
Name: _____

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

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Your connection to better care.

Patient Intake Questionnaire – 3 of 4

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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?**

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

List Allergies: _____

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Patient Intake Questionnaire – 4 of 4

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Name: _____

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

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

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

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