

NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

### INTAKE QUESTIONNAIRE

1. Describe Onset of Injury: \_\_\_\_\_

2. Please check (✓) no more than five (5) areas that this problem has created:

- turning door handle/open jar     getting in and out of car     participating in sports
- doing laundry     sitting to watch movie     turning head for car mirrors
- reaching into high cabinet     walking     walking the dog
- sexual activity     bathing, grooming     lifting/carrying
- putting on pants/socks/shoes     typing/computer     using a clutch/brake/gas
- speaking     sewing/knitting/crafts     shoveling snow
- swallowing liquids/solids     reaching for wallet     going up and down stairs
- gardening/yard work     stepping into shower/bathtub     other \_\_\_\_\_
- climbing a ladder     housecleaning/washing dishes/cooking

3. Please indicate all that apply:

- Increased:  General fatigue     stress     Family conflict
- Irritability/anger/hostility     Feeling hopeless/helpless     Nervousness/anxiety
- Decreased:  motivation for activities     Concentration/memory     Transportation for Therapy

4. When therapy is complete, what would you like to be able to do? \_\_\_\_\_

5. Does your problem(s) involve pain?  Y  N If yes, please mark on the line where you would rate your pain.

0    1    2    3    4    5    6    7    8    9    10  
 NO PAIN UNBEARABLE PAIN

6. Past Medical History (please indicate on the line the Month/Year of onset)

- heart attack     pacemaker     cancer
- diabetes, controlled by \_\_\_\_\_     high blood pressure     surgery \_\_\_\_\_
- bowel/bladder control problems     breathing problems     seizure disorders
- currently pregnant     pneumonia     history of falls
- stroke/head injury     arthritis/osteoporosis     other \_\_\_\_\_

7. List any medications you are currently taking: \_\_\_\_\_

8. If you are employed, please list your job duties: Check If yes, how much?

- lifting: what \_\_\_\_\_ # ; Currently limited: Y N \_\_\_\_\_#
- carrying: what \_\_\_\_\_ # ; Currently limited: Y N \_\_\_\_\_#
- climbing: what \_\_\_\_\_ # ; Currently limited: Y N \_\_\_\_\_#
- pushing/pulling: what \_\_\_\_\_ # ; Currently limited: Y N \_\_\_\_\_#
- sitting: how long \_\_\_\_\_ ; Currently limited: Y N \_\_\_\_\_mins.
- standing: how long \_\_\_\_\_ ; Currently limited: Y N \_\_\_\_\_mins
- other \_\_\_\_\_