FYZICAL®
Therapy & Balance Centers

INTAKE QUESTIONNAIRE

Today's Date: _____
Patient ID #: _____

Name:_____
Last First MI

Date of Birth:_____

Gender: □ Male □ Female

Are you: □ Right-handed □ Left-handed

Race
□ Asian
□ Black
□ White

Ethnicity
□ Hispanic
□ Non-Hispanic

Language
□ English understood?
□ Interpreter needed?
□ Language you speak most often? _____

Education
Highest grade completed (circle one): 1 2 3 4 5 6 7 8 9 10 11 12
□ Some college / technical school
□ College graduate
□ Graduate school / advanced degree

CURRENT CONDITION/CHIEF COMPLAINT(S)
Describe the problem(s) for which you seek physical therapy:
_____
_____
_____

When did the problem(s) begin (month and year)? _____

What happened? _____
_____

Have you ever had the problem(s) before?
□ Yes □ No
If yes,
What did you do for the problem(s)?_____
_____
Did the problem(s) get better?
□ Yes □ No
About how long did the problem(s) last?
_____

How are you taking care of the problem(s) now? _____
_____

What makes the problem(s) better? _____
_____

What makes the problem(s) worse? _____
_____

What are your goals for physical therapy? _____
_____

Current condition(s)/Chief complaint(s) cont.
Are you seeing anyone else for the problem(s)? (check all that apply.)
□ Acupuncturist
□ Cardiologist
□ Chiropractor
□ Dentist
□ Family Practitioner
□ Orthopedist
□ Osteopath
□ Pediatrician
□ Internist
□ Massage Therapist
□ Neurologist
□ Obstetrician/gynecologist
□ Occupational Therapist
□ Podiatrist
□ Primary Care Physician
□ Rheumatologist
Other _____

OTHER CLINICAL TESTS—within the past year, have you had any of the following tests? (Check all that apply.)
□ Angiogram
□ Arthroscopy
□ Biopsy
□ Blood tests
□ Bone scan
□ Bronchoscopy
□ CT scan
□ Doppler ultrasound
□ Echocardiogram
□ EEG (electroencephalogram)
□ EKG (electrocardiogram)
□ EMG (electromyogram)
□ Mammogram
□ MRI
□ Myelogram
□ NCV (nerve conduction velocity)
□ Pap smear
□ Pulmonary function test
□ Spinal tap
□ Stool tests
□ Stress tests (eg, treadmill, bicycle)
□ Urine tests
□ X-rays
□ Other: _____

MEDICAL HISTORY (check all that apply)
□ Heart attack
□ Heart valve problems
□ Deep venous thrombosis (blood clots in the legs)
□ Arterial blockage of the legs
□ High blood pressure
□ Stroke (including transient ischemic attacks/ministrokes)
□ Epilepsy/seizures
□ Asthma
□ Emphysema
□ Stomach/duodenal ulcers
□ Tuberculosis
□ Hypothyroid (low)
□ Hyperthyroid (high)
□ Pneumonia
□ Pelvic inflammatory disease
□ Chemical dependency (eg, alcoholism)
□ Diabetes (diagnosed before age 18 years)
□ Diabetes (diagnosed after age 18 years)
□ Multiple sclerosis
□ Rheumatoid arthritis
□ Degenerative osteoarthritis or wear-and-tear arthritis
□ Gout
□ Ankylosing spondylitis
□ Hepatitis
□ Depression
□ Endometriosis
□ Urinary incontinence
□ Osteoporosis
□ Bone or joint infection
□ Kidney infection
□ Headaches (more than 1 per week)
□ chronic urinary tract/bladder infections (3 episodes or more during the past 12 months)

Medical history cont.

□ Other infections
Please list _____

□ Other illnesses diagnosed by a physician.
Please list _____
_____

□ Cancer
Please list _____
_____

SURGICAL HISTORY (check all that apply and state date of surgery)

□ Cesarean section _____
□ Hysterectomy _____
□ Heart surgery (bypass) _____
□ Prostate surgery _____
□ Appendectomy _____
□ Gall bladder surgery_____
□ Bone/joint surgery _____
(total joint replacement, knee or shoulder surgery)
□ Carpal tunnel surgery _____
□ Hernia repair _____
□ Tonsillectomy _____
□ Other surgeries. Please list:
_____
_____
_____

MEDICATION

During the past week have you taken any of the following medications not prescribed by a physician?

□ Advil, Motrin, Aleve, Ibuprofen
□ Aspirin
□ Tylenol/acetaminophen
□ Antacids
□ Laxative
□ Decongestants/antihistamines
□ Tagamet, Zantac, Pepsid
□ Herbal medicines
□ Other medications. Please list:
_____
_____
_____

During the past week have you taken any of the following PHYSICIAN-prescribed medications?

□ Aspirin
□ Anti-inflammatories (eg. Motrin, Naprosyn, Relafen, Orudis)
□ Tylenol/acetaminophen
□ Muscle relaxers (eg. Valium)
□ Prescribed pain relievers(Darvocet, Darvon, Percocet, Vicodin, Tylenol with codeine)
□ Hormone replacement therapy (estrogens/progesterones)
□ High blood pressure medications
□ Water pills (diuretics) for reasons other than high blood pressure
□ Stomach ulcer medications
□ Heart medications (other than for high blood pressure)
□ Antibiotics
□ Thyroid medication
□ Asthma medications
□ Antidepressant medications
□ Insulin
□ Seizure medication
□ Decongestants/antihistamines for sinus or allergy problems
□ Other medications. _____
Please list: _____
_____
_____

SOCIAL HISTORY

Cultural / Religious

Any customs or religious beliefs or wishes that might affect care?

_____

With whom do you live?

□ Alone
□ Spouse only
□ Spouse and other(s)
□ Child (not spouse)
□ Other relative(s)(not spouse or children)
□ Group setting
□ Personal care attendant
□Other:_____

Have you completed an advance directive?

□ Yes □ No

Employment/Work (Job/School/Play):

□ Working full-time outside of home
□ Working part-time outside of home
□ Working full-time from home
□ Working part-time from home
□ Homemaker □ Student □ Retired □ Unemployed

Occupation: _____

LIVING ENVIRONMENT

Does your home have:
□ Stairs, no railing
□ Stairs, railing
□ Ramps
□ Elevator
□ Uneven terrain
□ Assistive devices
□ Any obstacles: _____

Do you use:
□ Cane
□ Walker
□ Manual wheelchair
□ Motorized wheelchair
□ Glasses, hearing aids
□ Other: _____

Where do you live?

□ Private home
□ Private apartment
□ Long-term care facility (nursing home)
□ Board and care / assisted living/ group home
□ Homeless (with/ without shelter)
□ Hospice
□ Rented Room
□ Other: _____

SOCIAL / HEALTH HABITS

Smoking:

Currently? □ Yes □ No
Smoked in past? □ Yes □ No

Alcohol:

- How many days per week do you drink beer, wine, or other alcoholic beverages, on average? ___
- If one beer, one glass of wine, or one cocktail equals one drink, how many drinks do you have, on an average day? ____

Exercise:

Do you exercise beyond normal daily activities and chores?

□ Yes Describe the exercise_____
On average, how many days per week do you exercise or do physical activity? _____
For how many minutes, on an average day? _____
□ No