

Patient INTAKE Survey Generic Form

Staff Only

Patient Identification Number	Survey Date	MM	DD	YYYY	Payer Source
Please select Patient Proxy, If applicable				Primary Clinician	
Spouse <input type="checkbox"/> Other Family <input type="checkbox"/> Caregiver <input type="checkbox"/> Other <input type="checkbox"/>					
Care Type	Body Part	Multiple Sites <input type="checkbox"/>		Impairment Category	Multiple Categories <input type="checkbox"/>
Patient Name (Last Name, First Name)	Date of Birth			Sex	
	MM	DD	YYYY	Male <input type="checkbox"/>	Female <input type="checkbox"/>

We are interested in how you feel about how well you are able to do your usual activities. This information will help us take better care of you. Please answer the questions based on the problem for which you are receiving treatment. If you do not do or have not done this activity, please make your best guess as to which response is most accurate.

1. Have you received treatments for this condition before? _____ Yes _____ No

Today, Does or would your health problem limit:	Yes, Limited a lot	Yes, Limited a little	No, Not limited at all
2. Participating in rigorous contact sports?			
3. Lifting 100 lbs. or more?			
4. Vigorous activities, such as running, lifting heavy objects, sports, running more than 5 miles?			
5. Participating in recreation?			
6. Moderate activities, such as moving a table or pushing a vacuum cleaner?			
7. Climbing several flights of stairs?			
8. Climbing one flight of stairs?			
9. Walking more than a mile?			
10. Walking several blocks?			
11. Walking one block?			
12. Walking around a room?			
13. Going on vacation?			
14. Attending social events?			
15. Lifting or carrying items like groceries?			
16. Lifting overhead to a cabinet?			
17. Gripping or opening a can?			
18. Handling of small items such as a pen or coins?			
19. Feeding yourself?			
20. Getting in and out of bed?			
21. Bathing or dressing?			
22. Bending to the floor?			
23. Kneeling to the floor?			
24. Control of your bladder?			
25. Completing your toileting?			

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	<table style="margin: auto; border-collapse: collapse;"> <tr> <td style="text-align: center; padding: 2px;">MM</td> <td style="text-align: center; padding: 2px;">DD</td> <td style="text-align: center; padding: 2px;">YYYY</td> </tr> <tr> <td style="border: 1px solid black; width: 40px; height: 25px;"></td> <td style="border: 1px solid black; width: 40px; height: 25px;"></td> <td style="border: 1px solid black; width: 60px; height: 25px;"></td> </tr> </table>	MM	DD	YYYY			
MM	DD	YYYY					

26. Do you limit the kind of work or other daily activities as a result of your physical health? Yes No

27. Do you reduce the amount of time you spend on work or other regular daily activities as a result of your physical health? Yes No

28. How much does pain interfere with your normal work (including work outside the home, work around the yard, and housework)?
 Extremely Quite a bit Moderately Not at all

29. How much pain have you had during the past 24 hours?
 Severe Moderate Mild None

30. Are you taking prescription medication for this condition? Yes No

31. How often have you completed at least 20 minutes of exercise such as jogging, cycling, or brisk walking, prior to the onset of your condition?
 At least 3 times per week Once or twice a week Seldom or never

32. Indicate the number of surgeries for your primary condition
 None 1 2 3 4 or more

33. How many days ago did this condition begin?
 0 - 7 8 - 14 15 - 21 22 - 90 91 - 6 mo. More than 6 mo.

34. I should not do physical activities which (might) make my pain worse.
 0 - Completely disagree 1 2 3 - Unsure 4 5 6 - Completely agree

35. Other health problems may affect your treatment. Please check any of the following problems that apply to you:

- | | |
|---|--|
| <input type="checkbox"/> Arthritis (rheumatoid / osteoarthritis)
<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Asthma
<input type="checkbox"/> Chronic Obstructive Pulmonary Disease (COPD),
acquired respiratory distress syndrome (ARDS)
or emphysema
<input type="checkbox"/> Angina
<input type="checkbox"/> Congestive Heart Failure (or heart disease)
<input type="checkbox"/> Heart Attack (Myocardial Infarction)
<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Neurological Disease
(such as Multiple Sclerosis or Parkinson's)
<input type="checkbox"/> Stroke or TIA
<input type="checkbox"/> Peripheral Vascular Disease
<input type="checkbox"/> Headaches
<input type="checkbox"/> Diabetes Types I and II
<input type="checkbox"/> Gastrointestinal Disease
(ulcer, hernia, reflux, bowel, liver, gall bladder) | <input type="checkbox"/> Visual Impairment (such as cataracts,
glaucoma, macular degeneration)
<input type="checkbox"/> Hearing Impairment (very hard of
hearing, even with hearing aids)
<input type="checkbox"/> Back Pain (neck pain, low back pain,
degenerative disc disease,
spinal stenosis)
<input type="checkbox"/> Kidney, Bladder, Prostate or
Urination Problems
<input type="checkbox"/> Previous Accidents
<input type="checkbox"/> Allergies
<input type="checkbox"/> Incontinence
<input type="checkbox"/> Anxiety or Panic Disorders
<input type="checkbox"/> Depression
<input type="checkbox"/> Other disorders
<input type="checkbox"/> Hepatitis / AIDS
<input type="checkbox"/> Prior Surgery
<input type="checkbox"/> Prosthesis / Implants
<input type="checkbox"/> Sleep dysfunction
<input type="checkbox"/> Cancer |
|---|--|

36. Height: _____ ft _____ in.

37. Weight: _____ lbs

