Prairie REHABILITATION SERVICES

Reviewing Therapist _____

Date _____

INTAKE QUESTIONNAIRE

A. PERSONAL INFORMATION

Name _____ Age _____ Sex _____ Today's Date _____

Height _____ Weight _____ ❑ Right Handed ❑ Left Handed

Occupation _____

Current Employer _____ Length of Employment _____

Check those items that apply to you:

❑ Full Time	❑ Employee	❑ Worker's Compensation
❑ Part Time	❑ Self-employed	❑ Pension/Long Term Disability
❑ Working with Restrictions	❑ Retired	❑ Social Security Disability Insurance
❑ Not Working	❑ Unemployed	❑ Other _____

Date of onset _____ Work or sports related ❑ Yes ❑ No Amount of time off work _____

Are you currently under any restrictions from your physician? ❑ Yes ❑ No If yes, explain specifically _____

_____

_____

_____

Is any litigation/insurance settlement regarding accident/injury pending? ❑ Yes ❑ No

B. HISTORY

When did this current episode begin? Date _____/_____/_____

Precisely, <u>where</u> did the symptoms begin? _____

Where have the symptoms spread? _____

Specifically, what is your present problem or complaint? _____

_____

_____

_____

How was this sustained? (accident, etc.) _____

_____

_____

_____

C. CURRENTLY

Is your pain ❑ Constant ❑ Intermittent

Is your pain getting ❑ Better ❑ Worse ❑ Not Changing

What eases your pain/symptoms ❑ Rest ❑ Activity ❑ Neither ❑ Other _____

Does your pain change as the day goes on? ❑ Yes ❑ No If yes, explain _____

Generally, how do the following activities affect your pain/symptoms?

Better	Worse	No Affect	Don't Know	
❑	❑	❑	❑	Sitting
❑	❑	❑	❑	Standing
❑	❑	❑	❑	Walking
❑	❑	❑	❑	Rest on Back
❑	❑	❑	❑	Rest on Stomach
❑	❑	❑	❑	Coughing/Sneezing
❑	❑	❑	❑	Sleeping

At this time, are you able to perform the following activities. If so, for how long?

Able to do	For How Long (minutes, hours)	Not able to do	
❑	_____	❑	Work while sitting
❑	_____	❑	Vacuuming
❑	_____	❑	Bending to tie shoes
❑	_____	❑	Comb/fix hair
❑	_____	❑	Work at kitchen sink
❑	_____	❑	Repetitive lifting
❑	_____	❑	Walk up stairs
❑	_____	❑	Walk down stairs
❑	_____	❑	Mow the lawn
❑	_____	❑	Reach into back pocket
❑	_____	❑	Lift overhead repeatedly
❑	_____	❑	Independent in self care

Do you have any loss of bladder or bowel control? ❑ Yes ❑ No

What previous treatments have been tried for the current condition?

Indicate the treatment and how helpful it was	Very	Some	Not at all
❑ Surgery, how many?_____	❑	❑	❑
❑ Nerve blocks	❑	❑	❑
❑ Injections	❑	❑	❑
❑ Brace/supportive device	❑	❑	❑
❑ Exercise	❑	❑	❑
❑ Prescribed bed rest	❑	❑	❑
❑ Traction	❑	❑	❑
❑ Ice/Heat	❑	❑	❑
❑ Ultrasound	❑	❑	❑
❑ Manipulation	❑	❑	❑
❑ Biofeedback	❑	❑	❑
❑ Work Hardening	❑	❑	❑
❑ Medications	❑	❑	❑
❑ Other	❑	❑	❑

D. GOALS

What are your goals for treatment? _____

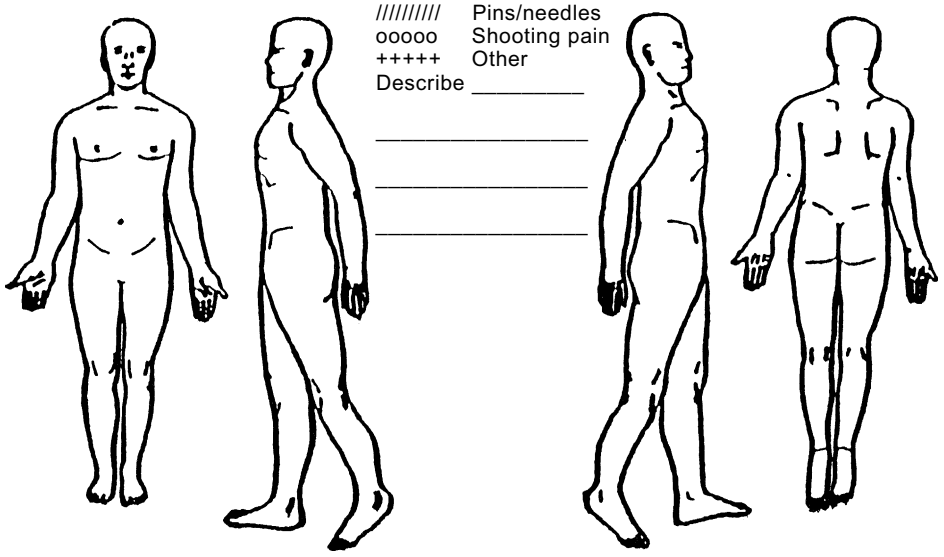
_____

E. DESCRIPTION OF YOUR PAIN

There are many words that describe pain. Some of these words are grouped below. If you are experiencing <u>any pain</u>, circle any word(s) that describe your pain.

1 Flickering Quivering Pulsing Throbbing Beating Pounding	10 Tender Rasping Splitting	**If you have pain or numbness, please shade areas on chart showing where it is.**
2 Jumping Flashing Shooting	11 Tiring Exhausting	
3 Pricking Boring Drilling Stabbing Lancinating	12 Sickening Suffocating	
4 Sharp Cutting Lacerating	13 Fearful Frightful Terrifying	
5 Pinching Pressing Gnawing Cramping Crushing	14 Punishing Grueling Cruel Vicious Killing	
6 Tugging Pulling Wrenching	15 Wretching Binding	
7 Hot Burning Scalding Searing	16 Annoying Troublesome Miserable Intense Unbeatable	
8 Tingling Itchy Smarting Stinging	17 Spreading Radiating Penetrating Piercing	
9 Dull Sore Hurting Aching Heavy	18 Tight Numb Drawing Squeezing Tearing	
	19 Cool Cold Freezing	
	20 Nagging Nauseating Agonizing Dreadful Torturing	

KEY
xxxxxx Numbness
////////// Pins/needles
ooooo Shooting pain
+++++ Other
Describe _____



ACCOMPANYING SYMPTOMS:	**SLEEP:**	**FOOD INTAKE:**
Nausea Headache Dizziness Drowsiness Constipation Diarrhea	Good Restless Can't Sleep	Good Some Little None

MARK AN "X" TO GRADE YOUR PAIN LEVEL No pain ——— Pain totally controls

F. PAST HISTORY

Have you ever had anything similar <u>before</u>? ❑ Yes ❑ No <u>If no</u>, skip to **G. PAST MEDICAL HISTORY** on page 4.

If yes, explain _____

_____

Did you receive any treatment in relation to the **PREVIOUS** episode? ❑ Yes ❑ No

Indicate treatment and how helpful it was	Very	Some	Not at all
❑ Surgery, how many?____	❑	❑	❑
❑ Nerve blocks	❑	❑	❑
❑ Injections	❑	❑	❑
❑ Brace/supportive device	❑	❑	❑
❑ Exercise	❑	❑	❑
❑ Prescribed bed rest	❑	❑	❑
❑ Traction	❑	❑	❑
❑ Ultrasound	❑	❑	❑
❑ Ice/Heat	❑	❑	❑
❑ Manipulation	❑	❑	❑
❑ Biofeedback	❑	❑	❑
❑ Work Hardening	❑	❑	❑
❑ Medications	❑	❑	❑

❑ Other, please describe

_____

_____

_____

_____

G. PAST MEDICAL HISTORY

In the past, have you had any serious injuries? ❑ Yes ❑ No If yes, please list and give dates _____

_____

Please describe below any vehicle accidents or personal injuries in which you have been involved.

AGE (OR APPROXIMATE YEAR)

0 - 10 _____
11 - 20 _____
21 - 30 _____
31 - 40 _____
41 - 50 _____
51 - 60 _____
61 & over _____

Have you had any operations or surgery? ❑ Yes ❑ No _____ If yes, list type of surgeries and dates

_____

Do you currently have or have you previously had any of the diseases listed below?

Yes	No		If yes, when diagnosed
❑	❑	High blood pressure	_____
❑	❑	Diabetes Mellitus	_____
❑	❑	Heart Disease	_____
❑	❑	Lung Disease	_____
❑	❑	Stomach Disorders (ulcer, etc.)	_____
❑	❑	Liver Disorders (hepatitis, etc.)	_____
❑	❑	HIV Positive	_____
❑	❑	Kidney and Bladder Control	_____
❑	❑	Glands (thyroid, etc.)	_____
❑	❑	Skin Disease	_____
❑	❑	Cancer	_____
❑	❑	Fainting Spells	_____
❑	❑	Vision Problems (not glasses)	_____
❑	❑	Hearing Problems	_____
❑	❑	Depression	_____
❑	❑	Other Physical or Mental Health Diagnosis	_____

Do you have any allergies? ❑ Yes ❑ No If yes, please list _____

Have you taken cortisone (steroids) by pill within the last 5 years? ❑ Yes ❑ No

Are you currently taking any medications? ❑ Yes ❑ No If yes, please list Prescriptions _____

_____

_____

Non-Prescription medications & Supplements _____

_____

Do you smoke? ❑ Yes ❑ No If yes, how much? _____

If you are female, is there any possiblity that you are pregnant: ❑ Yes ❑ No