Prairie REHABILITATION SERVICES

FOR INTERNAL USE ONLY
DOB_____
Last visit_____
POC ❑ Yes ❑ No
BP_____/_____
Heart Rate _____BPM

INTAKE QUESTIONNAIRE

A. PERSONAL INFORMATION

Name _____ Age_____ Sex _____Today's Date_____

Height _____ Weight _____ ❑ Right Handed ❑ Left Handed

Date of onset _____

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

_____

_____

B. HISTORY

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

Precisely, where did the symptoms begin? _____

Where have the symptoms spread?_____

Specifically, what is your present problem or complaint?_____

_____

_____

_____

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

_____

What was your previous level of function? _____

_____

C. CURRENTLY

Is your pain ❑ Constant ❑ Intermittent ❑ Not a Pain Problem

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

D. GOALS

What are your goals for treatment? _____

_____

E. PAST HISTORY

Have you ever had anything similar before? ❑ Yes ❑ No If no, skip to **F. PAST MEDICAL HISTORY.**

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
_____
_____
_____
_____

F. 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. **(<u>If a pain problem</u>)**

<u>AGE (OR APPROXIMATE YEAR)</u>

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

Have you had any operations? ❑ 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	_____
❑	❑	Stroke or TDA	_____
❑	❑	Depression	_____
❑	❑	Other - Please List	_____

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

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

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

_____

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