Patient INTAKE Survey
Generic Form

Name:	Date:
Date of Birth:	Sex:

1.) Have you received treatments for this condition before? ________________

How much does or would your health limit:	Limited a Lot	Limited a Little	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?			
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?			

26.) Do you limit the kind of work or other daily activities as a result of your physical health? _____

27.) Do you reduce the amount of time you spend on work or other regular daily activities as a result of your physical health? _____

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? ________________

31.) How often have you completed at least 20 minutes of exercise such as jogging, cycling, or brisk walking and prior to the onset of your condition.
____ 3 or more times per week ____Once or Twice a week ____Seldom or never

32.) How many surgeries have you had for this condition? __________________

33.) How many days ago did this condition begin? _________________________

34.) I am apprehensive about doing physical activities which might make my pain worse (circle one).

Completely disagree 1 2 3 4 5 6 7 Completely agree

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

_____Arthritis (rheumatoid/osteoarthritis) _____Osteoporosis _____Asthma _____Chronic Obstructive Pulmonary Disease or emphysema _____Angina _____Congestive Heart Failure (heart disease) _____Heart Attack (Myocardial Infarction) _____High Blood Pressure _____Neurological Disease (Multiple Sclerosis, Parkinson's) _____Stroke or TIA _____Peripheral Vascular Disease _____Headaches _____Diabetes _____Gastrointestinal Disease (ulcer, hernia, reflux, bowel, liver, gallbladder) _____Nausea/Vomiting _____Weight Loss/Gain	_____Visual Impairment _____Hearing Impairment _____Back Pain _____Kidney, Bladder, Prostate or Urination Problems _____Allergies (medication, latex) _____Incontinence _____Anxiety or Panic Disorder _____Depression _____Other disorders _____Hepatitis/AIDS _____Sleep dysfunction _____Cancer _____Fatigue _____ Fever/Chills/Sweats _____Numbness or Tingling _____Muscle Weakness _____Dizziness/Lightheadedness _____Difficulty with balance while walking _____Falls

Please list all medications you are currently taking:	**Please list all surgeries you have had:**