

**Patient INTAKE Survey**  
**Upper Body**  
 Neck, Cranium/Mandible, Thoracic Spine, Ribs

Name:	Date:
Date of Birth:	Sex:
Body Part:	

Today, how much does or would the problem for which you are seeking attention limit:	Limited a Lot	Limited a Little	Not Limited at All
1. Vigorous activities like running, lifting heavy objects, sports?			
2. Participating in recreation?			
3. Moderate activities like moving a table or pushing a vacuum cleaner?			
4. Lifting or carrying items like groceries?			
5. Lifting overhead to a cabinet?			
6. Gripping or opening a can?			
7. Handling small items such as a pen or coins?			
8. Feeding yourself?			
9. Getting in and out of bed?			
10. Bathing or dressing?			
11. Completing your toileting?			

12.) Please indicate the amount of pain you have had in the last 24 hours (circle one):

No Pain   0 1 2 3 4 5 6 7 8 9 10   Pain as bad as it can be

13.) Indicate the number of surgeries for your condition \_\_\_\_\_

14.) How many days ago did this condition begin? \_\_\_\_\_

15.) Are you taking prescription medication for this condition? \_\_\_\_\_

16.) Have you received treatment for this condition before? \_\_\_\_\_

17.) 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

18.) 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?

3 or more times per week     Once or twice a week     Seldom or Never

19.) What is your present employment status? (Mark one)

- Employed and presently working full duty at same job
- Employed and presently working full duty at different job
- Employed and presently working restricted duty at same job
- Employed and presently working restricted duty at different job
- Employed but presently not working due to my condition
- Previously employed and receiving disability benefits for my condition
- Unemployed
- Retired
- Student
- Other

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

<input type="checkbox"/> Arthritis (rheumatoid/osteoarthritis)	<input type="checkbox"/> Visual Impairment
<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Hearing Impairment
<input type="checkbox"/> Asthma	<input type="checkbox"/> Back Pain
<input type="checkbox"/> Chronic Obstructive Pulmonary Disease or emphysema	<input type="checkbox"/> Kidney, Bladder, Prostate or Urination Problems
<input type="checkbox"/> Angina	<input type="checkbox"/> Allergies (medication, latex)
<input type="checkbox"/> Congestive Heart Failure (heart disease)	<input type="checkbox"/> Incontinence
<input type="checkbox"/> Heart Attack (Myocardial Infarction)	<input type="checkbox"/> Anxiety or Panic Disorder
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Depression
<input type="checkbox"/> Neurological Disease (Multiple Sclerosis, Parkinson's)	<input type="checkbox"/> Other disorders
<input type="checkbox"/> Stroke or TIA	<input type="checkbox"/> Hepatitis/AIDS
<input type="checkbox"/> Peripheral Vascular Disease	<input type="checkbox"/> Sleep dysfunction
<input type="checkbox"/> Headaches	<input type="checkbox"/> Cancer
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Fatigue
<input type="checkbox"/> Gastrointestinal Disease (ulcer, hernia, reflux, bowel, liver, gallbladder)	<input type="checkbox"/> Fever/Chills/Sweats
<input type="checkbox"/> Nausea/Vomiting	<input type="checkbox"/> Numbness or Tingling
<input type="checkbox"/> Weight Loss/Gain	<input type="checkbox"/> Muscle Weakness
	<input type="checkbox"/> Dizziness/Lightheadedness
	<input type="checkbox"/> Difficulty with balance while walking
	<input type="checkbox"/> Falls

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