

Patient INTAKE Survey Medical / Neurological

Name:	Date:
Date of Birth:	Sex:

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. Walking more than a mile?			
3. Climbing several flights of stairs?			
4. Moderate activities like moving a table or pushing a vacuum cleaner?			
5. Lifting or carrying items like groceries?			
6. Bending, kneeling, stooping?			
7. Going on vacation?			
8. Climbing one flight of stairs?			
9. Lifting overhead to a cabinet?			
10. Getting in and out of a chair?			

11.) 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

12.) How many surgeries have you had for this condition? _____

13.) How many days ago did this condition begin? _____

14.) Are you taking prescription medication for this condition? _____

15.) Have you received treatment for this condition before? _____

16.) 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

17.) 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

18.) 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

19.) 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	<input type="checkbox"/> Other disorders
(Multiple Sclerosis, Parkinson's)	<input type="checkbox"/> Hepatitis/AIDS
<input type="checkbox"/> Stroke or TIA	<input type="checkbox"/> Sleep dysfunction
<input type="checkbox"/> Peripheral Vascular Disease	<input type="checkbox"/> Cancer
<input type="checkbox"/> Headaches	<input type="checkbox"/> Fatigue
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Fever/Chills/Sweats
<input type="checkbox"/> Gastrointestinal Disease	<input type="checkbox"/> Numbness or Tingling
(ulcer, hernia, reflux, bowel, liver, gallbladder)	<input type="checkbox"/> Muscle Weakness
<input type="checkbox"/> Nausea/Vomiting	<input type="checkbox"/> Dizziness/Lightheadedness
<input type="checkbox"/> Weight Loss/Gain	<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: