Patient INTAKE Survey
Generic Form

Staff Only

Patient Identification Number	Survey Date MM DD YYYY	Payer Source

Please select Patient Proxy, If applicable	Primary Clinician
Spouse ☐ Other Family ☐ Caregiver ☐ Other ☐	

Care Type	Body Part	Multiple Sites ☐	Impairment Category	Multiple Categories ☐

Patient Name (Last Name, First Name)	Date of Birth MM DD YYYY	Sex Male	Female

We are interested in how you feel about how well you are able to do your usual activities. This information will help us take better care of you. Please answer the questions based on the problem for which you are receiving treatment. If you do not do or have not done this activity, please make your best guess as to which response is most accurate.

1. Have you received treatments for this condition before? _____ Yes _____ No

Today, Does or would your health problem limit:	Yes, Limited a lot	Yes, Limited a little	No, 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 cleaner?			
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 carring 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?			

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26. Do you limit the kind of work or other daily activities as a result of your physical health? _____ Yes _____ No

27. Do you reduce the amount of time you spend on work or other regular daily activites as a result of your physical health? _____ Yes _____ No

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? _____ Yes _____ No

31. 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?
_____ At least 3 times per week _____ Once or twice a week _____ Seldom or never

32. Indicate the number of surgeries for your primary condition
____ None ____ 1 ____ 2 ____ 3 ____ 4 or more

33. How many days ago did this condition begin?
_____ 0 - 7 _____ 8 - 14 _____ 15 - 21 _____ 22 - 90 _____ 91 - 6 mo. _____ More than 6 mo.

34. I should not do physical activities which (might) make my pain worse.
___ 0 - Completely disagree ___ 1 ___ 2 ___ 3 - Unsure ___ 4 ___ 5 ___ 6 - Completely agree

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

_____ Arthritis (rheumatoid / osteoarthritis)
_____ Osteoporosis
_____ Asthma
_____ Chronic Obstructive Pulmonary Disease (COPD), acquired respiratory distress syndrome (ARDS) or emphysema
_____ Angina
_____ Congestive Heart Failure (or heart disease)
_____ Heart Attack (Myocardial Infarction)
_____ High Blood Pressure
_____ Neurological Disease (such as Multiple Sclerosis or Parkinson's)
_____ Stroke or TIA
_____ Peripheral Vascular Disease
_____ Headaches
_____ Diabetes Types I and II
_____ Gastrointestinal Disease (ulcer, hernia, reflux, bowel, liver, gall bladder)
_____ Visual Impairment (such as cataracts, glaucoma, macular degeneration)
_____ Hearing Impairment (very hard of hearing, even with hearing aids)
_____ Back Pain (neck pain, low back pain, degenerative disc disease, spinal stenosis)
_____ Kidney, Bladder, Prostate or Urination Problems
_____ Previous Accidents
_____ Allergies
_____ Incontinence
_____ Anxiety or Panic Disorders
_____ Depression
_____ Other disorders
_____ Hepatitis / AIDS
_____ Prior Surgery
_____ Prosthesis / Implants
_____ Sleep dysfunction
_____ Cancer

36. Height: _____ ft _____ in.

37. Weight: _____ lbs