

DUBUQUE PHYSICAL THERAPY

Intake Questionnaire

(FRONT ONLY)

Patient's Name: _____

Date of Birth: _____

SS#: _____

Referring Physician: _____

Dominant Side: R L B Injured Side: R L B

Onset Date: _____

Please rate your current pain on a scale of 0 - 10
0 Represents NO PAIN and 10 is UNBEARABLE PAIN

AT REST 0 1 2 3 4 5 6 7 8 9 10 UNBEARABLE
DURING ACTIVITY 0 1 2 3 4 5 6 7 8 9 10 UNBEARABLE

Comorbidities

<input type="checkbox"/> None	<input type="checkbox"/> High blood pressure
<input type="checkbox"/> Bleeding disorder	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Connective tissue disease	<input type="checkbox"/> Smoker
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Asthma
<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Cancer
<input type="checkbox"/> Heart condition	<input type="checkbox"/>

Frequency of Pain

<input type="checkbox"/> No pain
<input type="checkbox"/> 1-3 times per week
<input type="checkbox"/> 4 or more times per week
<input type="checkbox"/> 1-3 times per day
<input type="checkbox"/> 4 or more times per day
<input type="checkbox"/> Constant

Previous Treatments

<input type="checkbox"/> Other Tissue Treatments	<input type="checkbox"/> Splints/braces
<input type="checkbox"/> None	<input type="checkbox"/> Injections
<input type="checkbox"/> Occupational Therapy	<input type="checkbox"/> Surgery
<input type="checkbox"/> Chiropractic Care	<input type="checkbox"/> Physical Therapy
<input type="checkbox"/> Orthotics	<input type="checkbox"/> Other

Functional Ability (job, sport, activity)

<input type="checkbox"/> Full functional ability
<input type="checkbox"/> Able to function with restrictions
<input type="checkbox"/> Able to function, no restrictions with brace/splint
<input type="checkbox"/> Able to function, restrictions with braces/splint
<input type="checkbox"/> Unable to function

Patient Type

<input type="checkbox"/> Competitive athlete	<input type="checkbox"/> Senior
<input type="checkbox"/> Other	<input type="checkbox"/> Workers comp
<input type="checkbox"/> Recreational	

1. What are you unable to do as a result of your condition?
2. If injured in a particular sport, which sport?
3. Are you taking medication for this problem?
4. What are your goals for therapy as they relate to question #1?
5. Is there litigation pending in this case?

