PACE PHYSICAL THERAPY INTAKE QUESTIONNAIRE: Today's date: _____

I. PERSONAL INFO: Name: _____

II. EMPLOYMENT: A. Occupation/job title: _____

B. If not working, number of days/weeks/months/years you have been off work: _____

C. Are you currently under any restrictions from your doctor? ( ) yes ( ) no If yes, explain specifically: _____

III. CURRENT HISTORY

A. Specifically, what is your present problem or complaint? _____

_____

B. When did this current episode begin?

Date of injury: _____/_____/_____ Date of surgery: _____/_____/_____

Date when problem started: _____

C. What caused the current condition?

_____

D. For the following, circle the underlined words or numbers which are most appropriate.

1. Rate the intensity of your pain:

At its worst: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst imaginable pain)

At its best: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst imaginable pain)

On average: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst imaginable pain)

2. Is your pain: Constant or does it Come and go

3. Is your pain getting: Better Worse Not changing

E. 1. What position or activity eases your pain the most? _____

_____

2. What position or activity aggravates your pain the most? _____

_____

F. Current Activity level: 0% = bedridden 100% = able to perform all pre-injury activities

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

IV. MEDICAL HISTORY

A. Circle the underlined words which are appropriate. Do you have any history of?

heart disease lung disease cancer diabetes arthritis high blood pressure
mental disorder stomach disorder pacemaker metal implant allergies
bleeding tendencies major operations serious personal injuries
difficulty with control of bowel or bladder function any numbness in the genital or anal area
any dizziness or fainting attacks unexplained weight loss
severe pain while in bed at night fever/chills/night sweats > 1 - 2 weeks duration

Please list specific health problems and/or major operations: _____

_____

_____

B. How is your general health? poor fair good excellent

What is your current stress level? low average high

C. Circle the underlined words that are appropriate.

Are you currently or have you recently taken any?: steroids (e.g. cortisone) muscle relaxants
pain killers anti-inflammatories blood thinners others

D. If you know the name(s) of your medication(s), please list: _____

_____

E. Is there any chance you may be pregnant at this time? Circle one. Yes No

F. Circle the underlined words that are appropriate.

Since the onset of this problem, have you had?

MRI CT Scan X-Rays Injections Nerve Blocks

Bone Scan Chiropractic Treatment Physical Therapy Other: _____

Describe results: _____

_____