Xcel Physical Therapy
Intake Questionnaire

Name:____
Employed_____ Not working _____Disabled _______ Retired ________Student ________
Employer Name: ________________________ Employer Phone: _______________

What is your occupation? ____

Marital Status: Married ______ Divorced_______ Widow _______ Single ____

Are you pregnant or is there a chance that you might be pregnant? ______Yes ______No

Date of injury/when condition began: ____________

Prior to your injury did you have any limitations or restrictions: ______Yes ______No
If yes, did you use any equipment such as walking aides or reachers _____Yes _____No

Have you previously injured this body part? Yes____ No ____
If so, when : _____________________________________

Is this a work related injury? Yes______ No _____
If so did you lose time from work due to this injury? Yes____ No _____
If yes, have you returned to work? Yes _____ No_____
Please tell us how much lost time from work you suffered? ______weeks _____ months

Is this an auto related injury? Yes ______ No _____

Have you ever sought medical attention following a vehicle accident? Yes ______No _____

Using this scale rate your pain over the past 48 hours: (no pain) 0-1-2-3-4-5-6-7-8-9-10 (most severe pain)
At the Worst_____ Best _____ Now _____

What is your height? ___feet ____ inches; What is your weight? _____ pounds

Social History
Do you live: alone____ with spouse____ with family ____
Are there any children or dependants that reside in your home? Yes (how many)____ No___
How many stairs to get into dwelling?: _____ How many stairs inside dwelling?: _____
Are there cultural/religious practices that we should respect during your therapy?
If so please explain:____
Do you smoke? **No Yes** (packs per day_____)
Do you <u>regularly</u> consume alcoholic beverages? **No Yes** (amount per day________________)
Have you recently had any additional stress in your life? **No Yes**
If yes, please explain: ____

Which diagnostic tests have been performed on you for this condition?
________MRI ________CT Scan __________X-ray ________ Bone Scan
________EMG/NCV (nerve test) __________Lab/Blood Tests

Past Medical History (please check all that apply)

High Blood Pressure ___	Cancer ___	Low Back Pain ____
Heart Attack ___	Heart Disease ___	Neck Pain ____
Pacemaker ___	Osteoarthritis ___	Osteoporosis ____
Rheumatoid Arthritis ____	Seizures ___	Epilepsy ____
Diabetes ___	Asthma ___	Lung Condition/COPD ____
Polio ___	Headaches ___	Fainting/Dizziness ____
Fractures ____	High Cholesterol ___	Peripheral Vascular Disorders ___
Cardiac arrhythmia ____	Depression ___	Stroke ___
Migraines ____	Headaches ____	Kidney Stones ____
Anemia ____	Gout _____	Shingles ______

Other (please list): ____
____

Surgeries (list all): ____
____

Current Pain Medications (please check all that apply)**:**

Advil/Motrin/Ibuprofen___	Vicodin____	Darvocet _____
Tylenol/Acetaminophen___	Flexeril/Skelaxin___	Oxycontin/Oxycodone___
Capsaicin ____	Hydrocodone____	Lidoderm/Lidocaine patch___
Lortab_____	Norco____	Morphine (MS Contin)_____
Gabapentin (Neurontin) ____	Pregabalin (Lyrica)___	Carbamazepine (Tegretol) ____
Duloxetine (Cymbalta) ____	Amitriptyline _____	Percocet ___
Ultracet ____	Ultram (Tramadol)___	Darvon ___
Duragesic (Fentanyl) patch___	Codeine ____	Hydromorphine (Dilaudid or Palladone) ___
Meperidine (Demerol) ___	Valium____	Mephobarbital (Mebaral) ____
Alprazolam (Xanax) ____	Cymbalta _____	Flexor Pain Patch ______
Chlordiazepoxide HCL (Librium) ____		Pentobarbitalsodium (Nembutal) ___
Naprosyn/Naproxyn/Aleve/Anaprox _______		Other: _________________________

Other Medications: ____
____

Please check any of the following symptoms you currently have or had around the time of your injury:

___History of steroid/corticosteroid use	___Excessive thirst
___Fever or night sweats	___Unexplained Sweat
___Loss of bowel or bladder control	___Unexplained fatigue
___Pain that awakens you at night	___Pain/difficulty with urination or discharge
___New or unexplained skin rashes or jaundice	___Blood in urine or change in color of stools
___Recent unexplainable loss of weight	___Nausea or vomiting

___Pain that increases or worsens with recumbency (lying down)
___Dizziness or shortness of breath with usual activities