Longview Orthopaedic Clinic

409 N. Sixth Street
Longview, TX 75601

Intake Questionnaire

Patient Information

1. Patient's Name: ______________________________
2. Address: ______________________________
3. Home Telephone No.: ______________________________
4. Work Telephone No.: ______________________________
5. Emergency Contact: ______________________________
   Relationship: ________________ No.: ____________
6. Race: (Circle One)
   White Black Hispanic
   Asian Other ________________
7. Sex: (Circle One) Female Male
8. Date of Birth: ____________ Age: ____________
9. Cultural/ Religious: Do you have any customs or religious beliefs/ wishes that might affect your care? ________________
10. Employment: (Circle One)
    Full-Time Part-Time Homemaker
    Student Retired Unemployed
11. Work Related Injury? (Circle One) Yes No
12. Where do you live?
    - Private Home
    - Private Apartment
    - Assisted Living
    - Nursing Home
    - Hospice
    - Other __________________________
13. Does your home have:
    - Stairs, no railing
    - Stairs, with railing
    - Ramps
    - Uneven terrain/surfaces
    - Bath bench/ grab bars
    - Other obstacles ____________________

14. Do you use:
    - Cane
    - Walker or rolling walker
    - Manual wheelchair
    - Motorized wheelchair
    - No assistive device
15. Health Habits

    Smoking

    Do you smoke? (Circle One) Yes No

    Cigarettes- # pack per day? ______

    Cigars- # per day? ______

    How many years have you smoked? ______

    Smoked in the past? Year quit? __________

    Drinking

    How many days per week do you drink an alcoholic beverage? _________

    How many drinks do you have on an average day? ___________________
16. Family History (Has any family member had:)
    - Heart Disease
    - Hypertension
    - Stroke
    - Diabetes
    - Cancer
    - Psychological disorder
    - Arthritis
    - Osteoporosis
    - Other _____________________
17. Medical History (Indicate if you have/had:)
    - Arthritis
    - Broken bones
    - Osteoporosis
    - Blood disorders
    - Circulation problems
    - Heart problems
    - High blood pressure
    - Lung problems
    - Stroke
    - Diabetes
    - Hypoglycemia
    - Head injury
    - Depression
    - Polio
    - Stomach problems
    - Pregnant/pregnancy
    - Muliple sclerosis
    - Muscular dystrophy
    - Parkinson's disease
    - Seizures/epilepsy
    - Allergies
    - Thyroid problems
    - Cancer
    - Tuberculosis
    - Hepatitis
    - Kidney problems
    - Repeated infections
    - Dizziness/ vertigo
    - Migraines
    - Skin diseases
    - Other: _______________

18. Within the past year, have you had any of the following symptoms? (Circle all the apply)

- Chest pain
- Weight gain/loss
- Pain at night
- Fever/chills
- Dizziness
- Difficulty swallowing
- Blackouts
- Hearing problems
- Urinary problems
- Coordination problems
- Numbness/weakness
- Nausea/vomiting
- Difficulty sleeping
- Loss of appetite
- Nights sweats
- Shortness of breath
- Difficulty talking
- Vision problems
- Headaches
- Bowel problems
- Frequent itching
- Loss of balance
- Fatigue
- Ringing in ears

19. Do you take any prescripion medications?

Yes No

If yes, please list: ______________________________

20. Do you take any non-prescription medications?

Check all that apply:

- Advil/ Aleve
- Decongestant
- Ibuprofen/ naproxen
- Aspirin
- Tylenol
- Antacids
- Antihistamines
- Herbal supplements

21. Reason for visit/Chief Complaint: ______________________________

Have you ever had this problem before? Yes No

What did you do for it? ______________________________

Did the problem get better? Yes No

What makes the problem worse? ______________________________

What makes the problem better? ______________________________

What is your goal for physical therapy? ______________________________

22. Are you seeing anyone else for the problem? Yes No

If yes, who? ______________________________

23. Within the last year, have you had any of the following test? (Check all that apply)

- Angiogram
- Bone scan
- Echocardiogram
- Urine test
- Arthoroscopy
- Bronchoscopy
- ECG/EKG/EEG/EMG
- MRI/CT Scan
- Pulmonary function test
- X-rays
- Biopsy
- Myelogram
- Spinal tap
- Blood tests
- Doppler ultrasound
- Nerve conduction
- Stool tests
- Other: ______________ ______________