

409 NORTH SIXTH STREET • LONGVIEW, TEXAS 75601  
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## 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    Student    Retired    Homemaker    Unemployed

11. Work Related Injury? (Circle One)    Yes    No

12. Where do you live? (Circle One)

- Private Home
- Private Apartment
- Assisted Living
- Nursing Home
- Hospice
- Other \_\_\_\_\_

13. Does your home have: (Circle all that apply)

- 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 | • Psychological disorder |
| • Hypertension  | • Arthritis              |
| • Stroke        | • Osteoporosis           |
| • Diabetes      | • Other                  |
| • Cancer        |                          |
- 

17. Medical History (Indicate if you have/had: )

- |                        |                       |
|------------------------|-----------------------|
| • Arthritis            | • Muscular dystrophy  |
| • Broken bones         | • Parkinson's disease |
| • Osteoporosis         | • Seizures/epilepsy   |
| • Blood disorders      | • Allergies           |
| • Circulation problems | • Thyroid problems    |
| • Heart problems       | • Cancer              |
| • High blood pressure  | • Tuberculosis        |
| • Lung problems        | • Hepatitis           |
| • Stroke               | • Kidney problems     |
| • Diabetes             | • Repeated infections |
| • Hypoglycemia         | • Dizziness/ vertigo  |
| • Head injury          | • Migraines           |
| • Depression           | • Skin diseases       |
| • Polio                | • Other               |
-

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

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

19. Do you take any prescription medications?

Yes No

If yes, please list: \_\_\_\_\_

20. Do you take any non-prescription medications? Check all that apply:

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

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 tests? (Check all that apply)

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