OUTPATIENT INTAKE QUESTIONNAIRE

Patient Name: _____ DOB: _____ Today's date: _____

How did you hear about us? _____

With respect to the condition that brings you to therapy, how would you describe yourself now compared to immediately after you condition occurred? *(Please circle the appropriate number)*

-5	-4	-3	-2	-1	0	1	2	3	4	5
Much Worse					Unchanged					Completely Recovered

Please check if you have ever had:

○ Arthritis/gout	○ Low blood sugar/hypoglycemia	○ Kidney problems
○ Broken bones/fractures	○ Head injury	○ Repeated infections
○ Osteoporosis	○ Ulcers/stomach problems	○ Blood disorders
○ Neurological problems	○ Skin diseases	○ Circulation/vascular issues
○ Parkinsons Disease	○ Multiple Sclerosis	○ Depression
○ Cardiac problems	○ Seizures/epilepsy	○ High blood pressure
○ Lung problems	○ Stroke	○ Diabetes/high blood sugar
○ Cancer	○ Thyroid problems	○ Other _____

Please explain any checked box above: _____

_____

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

○ Hospitalization	○ Falls, loss of balance	○ Difficulty walking
○ Urinary problems	○ Heart palpitations	○ Chest pain
○ Joint pain or swelling	○ Fever/chills/sweats	○ Cough
○ Pain at night	○ Headaches	○ Difficulty sleeping
○ Hearing problems	○ Vision problems	○ Shortness of breath
○ Loss of appetite	○ Dizziness or blackouts	○ Nausea/vomiting
○ Coordination problems	○ Difficulty swallowing	○ Bowel problems
○ Weight loss/gain	○ Weakness in arms or legs	○ Other _____

Please provide the name of your primary care provider and any other doctor's you have seen in the last year:

_____

Have you ever had any surgery? _____ If yes, please describe and include dates: _____

_____

Have you had any testing done recently (x-rays, MRI, CT scan, blood testing, neurological testing)? If so, what were the results? _____

Have you had any illness within the last 3 weeks (i.e. cold, flu, bladder or kidney infection)?

_____

Patient Name: _____ **Date:** _____

Do you have discomfort, shortness of breath, or pain with exercise? _____

Do you smoke? _____ If so, how much? _____

List any current medications you are taking both prescription and non-prescription:

_____

_____

_____

List any allergies, including medications: _____

_____

Who is your insurance provider? (Medicare, Medicaid, Blue Cross Blue Shield, Humana, etc.) _____

Are you receiving Home Health Care Services at this time? _____

What is your occupation/ or retired from? _____

Do you engage in regular exercise? _____ What type and how often? _____

Please describe the problem (s) for which you seek outpatient treatment: _____

_____

When did the problem(s) begin (date)? _____

Have you ever had the problem(s) before? If yes, please describe: _____

_____

Have you ever received therapy or any other treatment for this condition? What type and Where?_____

_____

Do you use any special supports or devices? _____

Has the current condition, for which you are seeking therapy, affected your ability to perform any of the following?

- Personal care (dressing, bathing)
- Pushing/pulling
- Standing
- Running/jumping
- Lifting, bending, kneeling, stooping
- Sitting
- Driving
- Leisure/recreational activities
- Getting in/out of bed, chair, car
- Walking
- Climbing stairs
- Family/home responsibilities

In case of emergency, who should be notified (Please include phone #'s) _____

_____

Your address: _____

Your phone number: _____

Patient Signature: _____

Signature of patient designee (if needed): _____