PHYSICAL THERAPY QUESTIONNAIRE / Intake Form

Date: _____

Name: _____ Height_____Weight _____ Age _____

Occupation: _____

Living environment: _____ Do you live alone? Yes No

If no, who do you live with:_____

Does your home have:

____Stairs, no railing ____Stairs, w/railing ____Ramps ____Elevator

____Uneven Terrain ____Other: _____

General Health

Do you use:

____Cane ____Walker or rollator ____Manual Wheelchair ____Motorized wheelchair

____Other_____

Please rate your health:

____Excellent ____Good ____Fair ____Poor

Health Habits

Do you exercise regularly? _____ Yes _____No

If yes, how often and what type of activities?

_____

_____

Past Medical History:

Please check if you have ever had:

____ High blood pressure
____ Arthritis
____ Blood disorders
____ Broken bones
____ Cancer: _____
____ Vascular problem
____ Depression
____ Infectious disease (such as tuberculosis, hepatitis)
____ Kidney problems
____ Low blood sugar
____ Lung problems
____ Multiple sclerosis
____ Osteoporosis
____ Developmental problems
____ Diabetes
____ Stroke
____ Thyroid problems
____ Parkinson's diseases
____ Seizures/epilepsy
____ Heart problems

Medications:

Do you take any prescription medications? ___ Yes ___ No

If yes, please list:

_____

_____

_____

_____

Family History
(Indicate whether mother, father, brother/sister, aunt/uncle, or grandmother/grandfather had any of the
following disorders and provide age of onset if known)
Heart disease: _____
Hypertension: _____
Stroke: _____
Diabetes: _____
Cancer:_____
Other: _____

Current Limitation (Check all that apply)
___ Difficulty with bed mobility
___Difficulty with transfers (such as moving from bed to chair, from bed to commode)
___ Difficulty walking on level surface ___ on stairs
___on ramps ___ on uneven terrain
___Difficulty with self-care (such as bathing, dressing, eating, toileting)
___Difficulty with household chores, shopping, driving
___ Difficulty with community and work activities/integration
___ Difficulty work/school ___ Difficulty recreation or play activity

History of Current Problem(s)
When did the problem(s) begin? ____/____/____ What occurred?
_____
_____
Have you ever had the problem(s) before? ___ Yes ____ No
What did you do for the problem(s)?
_____
_____
Did the problem(s) get better? ____ Yes ____ No
About how long did the problem last? _____
What makes the problem better / worse?_____
_____
What activities are you not able to do now that you could do before the problem(s)? (Please be as specific as you can; for example "Unable to reach over my head")
_____
_____
_____

South Alabama Physiotherapy

Rate the level of your pain on the following scale.

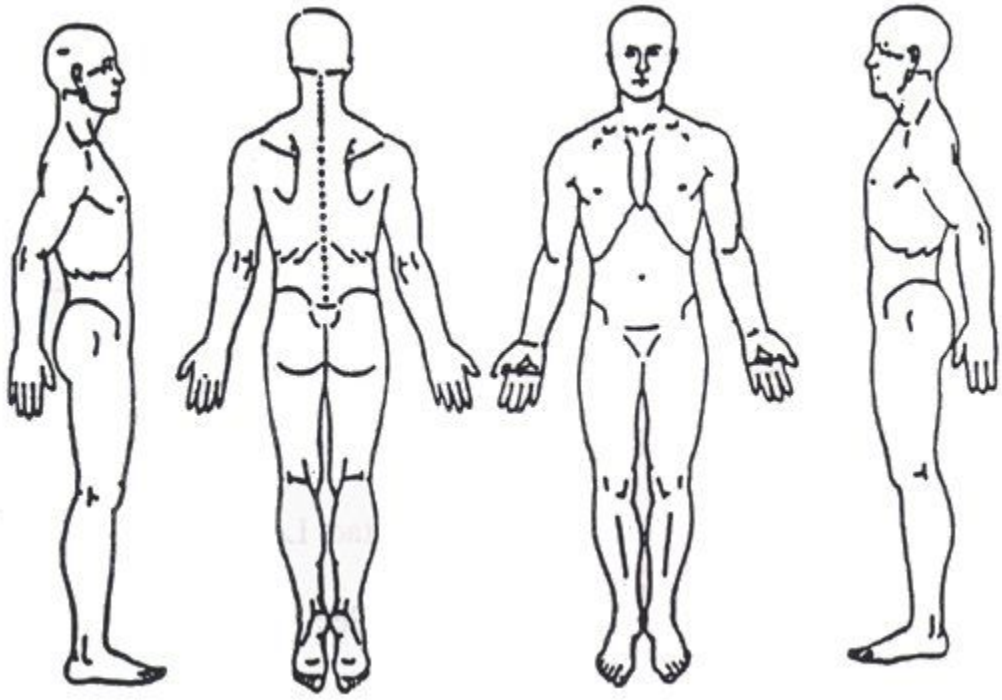
At present:	0	1	2	3	4	5	6	7	8	9	10
At best:	0	1	2	3	4	5	6	7	8	9	10
At worst:	0	1	2	3	4	5	6	7	8	9	10

(no pain) (moderate) (extreme)

Please draw pain on body chart

Pain description (please circle): Sharp Dull Burning Aching Tingling Numbness

+ = numbness 0 = pins/needles



Patient:_____