SYNERGY
Physical Therapy and Yoga Inc.

Patient Intake Questionnaire

Date of injury or date when you first noticed symptoms _____/_____/_____

Where did injury first occur: ☐at work ☐at home ☐Motor vehicle accident ☐Recreation

☐Other: _____

Please explain how injury occurred:

_____

Describe your symptoms at onset of condition:_____

Describe your symptoms now (if different):_____

What activities make your symptoms better? (i.e. treatments, positions)

_____

What activities make your symptoms worse? (i.e. treatments, positions)

_____

What specific activities can you not do or are difficult to perform because of your symptoms?

_____

What was your prior level of physical activity? (i.e. exercise, hobbies) –

List activity level:

Inactivity ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 Daily Intense Exercise

Please rate the following:

	No Pain										Excruciating
Pain at its worst	☐0	☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8	☐9	☐10
Pain at its best	☐0	☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8	☐9	☐10
Pain right now	☐0	☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8	☐9	☐10

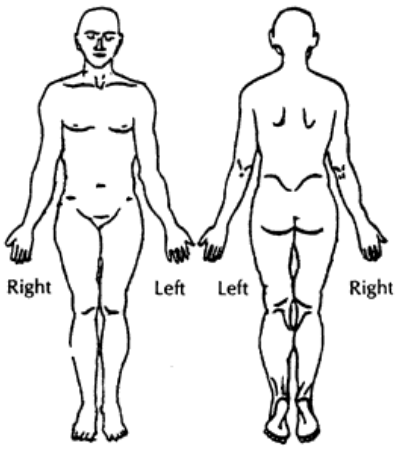
Using the diagram below, please indicate the location of symptoms listed.

+++Sharp Pain //// Dull Pain ---- Numbness xxx Burning Pain ooo Pins and Needles zzz Deep Ache

Location _____
Pain level _____

Location _____
Pain level _____

Location _____
Pain level _____



Location _____
Pain level _____

Location _____
Pain level _____

Location _____
Pain level _____

Please indicate which, if any, tests you have had for your condition: ☐X-ray ☐MRI ☐Cat Scan ☐EKG ☐Bone Scan ☐Nerve Conduction Study/EMG ☐Holter Monitor ☐Stress Test

Please list all treatments you have received for your condition (include dates and place of care):

_____

Please list all current medications (include vitamins, herbs, over-the-counter and prescribed):

_____

Were you hospitalized for this injury/condition? ☐No ☐Yes If yes, when?_____

Have you had any similar injuries in the past? ☐No ☐Yes If yes, please explain:

_____

Dates of work missed due to injury?_____

Patient Signature: _____ Date: _____

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Please indicate if **you** have ever had (check all that apply):

Allergies	Osteoporosis	Seizures/epilepsy	Parkinson disease
Arthritis	Cancer	Stroke	Kidney problems
Blood disorders	Multiple sclerosis	Skin diseases	Ulcers/stomach problems
Depression	Hypothyroid	Hyperthyroid	Diabetes- Type 1/ Type 2
Broken Bones/fractures_____		Low blood sugar/hypoglycemia	
Developmental /growth problems		Infectious disease (eg. tuberculosis, hepatitis)	
Repeated infections		Muscular dystrophy	Other: _____

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

Weakness in arms or legs		Fever/chills/sweats	Major life changes
Hoarseness	Coordination problems	Difficulty walking	Difficulty sleeping
Joint pain/swelling	Difficulty swallowing	Depression	Loss of appetite
Weight loss/gain	Headaches	Vision	Cough

Please list any other conditions or symptoms you are experiencing if not listed above:_____

For men only: Have you been diagnosed with prostate disease? Yes No

For women only: Are you experiencing any gynecological or obstetrical difficulties? Yes No

If yes, please describe any symptoms you think would be helpful_____

Pregnant, or think you might be pregnant? Yes No If yes, please describe:_____

Cardiovascular: Have **you** ever had any of the following (check all that apply):

Heart problems	Lung problems	Thyroid problems_____	Shortness of breath
Diabetes	Circulation, vascular problems		Heart palpitations
Dizziness/blackouts	High blood pressure	High Cholesterol	Chest pain

Currently smoke tobacco? Yes No If yes, how many packs per day? _____

Smoked in the past? Yes No If yes, year quit: _____

How many days per week do you drink alcoholic beverages, on average? _____ (N/A)

How many days per week do you exercise beyond normal daily activities? _____How many minutes/day? _____

During the past month, have you been bothered by feeling down, depressed or hopeless? Yes No

During the past month, have you often been bothered by little interest or pleasure when doing things? Yes No

If yes, are you being treated? Yes No If no, please explain:_____

Do you use:

Cane	Glasses	Walker	Hearing aid
Ramps	Wheelchair	Elevator	Assistive devices (e.g., bathroom)

Other: _____

Does your living environment have: Stairs **(no railing)** Stairs **(railing)** Uneven terrain

Any obstacles:_____

Please indicate your goals and expectations of therapy (i.e. return to activities):

Patient Signature: _____Date: _____

Printed Name: _____

Thank you for completing this form