

Patient INTAKE Survey

Upper Body
Neck, Cranium/Mandible, Thoracic Spine, Ribs

Staff Only

Patient Identification Number	Survey Date	MM	DD	YYYY	Payer Source
		<input type="text"/>	<input type="text"/>	<input type="text"/>	
Please select Patient Proxy, If applicable				Primary Clinician	
Spouse <input type="checkbox"/> Other Family <input type="checkbox"/> Caregiver <input type="checkbox"/> Other <input type="checkbox"/>					
Care Type	Body Part	Multiple Sites		Impairment Category	Multiple Categories
		<input type="checkbox"/>			<input type="checkbox"/>
Patient Name (Last Name, First Name)		Date of Birth			Sex
		MM	DD	YYYY	Male <input type="checkbox"/> Female <input type="checkbox"/>
		<input type="text"/>	<input type="text"/>	<input type="text"/>	

We are interested in how you feel about how well you are able to do your usual activities. This information will help us take better care of you. Please answer the questions based on the problem for which you are receiving treatment. If you do not do or have not done this activity, please make your best guess as to which response is most accurate.

Today, Does or would your health problem limit:	Yes, Limited a lot	Yes, Limited a little	No, Not limited at all
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1. VIGOROUS ACTIVITIES like running, lifting heavy objects, participating in strenuous sports?			
2. Participating in RECREATION?			
3. MODERATE ACTIVITIES like moving a table or pushing a vacuum cleaner, bowling, or playing golf?			
4. LIFTING or CARRYING items like groceries?			
5. LIFTING OVERHEAD to a cabinet?			
6. GRIPPING or OPENING a can?			
7. Handling SMALL Items like pens or coins?			
8. FEEDING yourself?			
9. Getting In and Out of BED?			
10. BATHING or DRESSING?			
11. Completing your TOILETING?			

12. Please indicate the amount of pain you have had in the last 24 hours (Please circle Number):
 No Pain _____ Pain as bad as it can be
 0 1 2 3 4 5 6 7 8 9 10

13. Indicate the number of surgeries for your primary condition ____0 ____1 ____2 +

14. How many days ago did this condition begin?
 ____0 - 7 ____8 - 14 ____15 - 21 ____22 - 90 ____91 - 6 mo. ____More than 6 mo.

15. Are you taking prescription medication for this condition? ____ Yes ____ No

16. Have you received treatments for this condition before? ____ Yes ____ No

17. I should not do physical activities which (might) make my pain worse.
 ____0 - Completely disagree ____1 ____2 ____3 - Unsure ____4 ____5 ____6 - Completely agree

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Patient Identification Number	Survey Date <table border="1" style="display: inline-table; vertical-align: middle;"> <tr> <td style="width: 30px; text-align: center;">MM</td> <td style="width: 30px; text-align: center;">DD</td> <td style="width: 60px; text-align: center;">YYYY</td> </tr> <tr> <td style="width: 30px; height: 20px;"></td> <td style="width: 30px; height: 20px;"></td> <td style="width: 60px; height: 20px;"></td> </tr> </table>	MM	DD	YYYY			
MM	DD	YYYY					

18. How often have you completed at least 20 minutes of exercise such as jogging, cycling, or brisk walking, prior to the onset of your condition?
 At least 3 times per week Once or twice a week Seldom or never

19. What is your present employment status? (Mark ONE response only)
 Employed and presently working full duty at same job
 Employed and presently working full duty at different job
 Employed and presently working restricted duty at same job
 Employed and presently working restricted duty at different job
 Employed but presently not working due to my condition
 Previously employed and receiving disability benefits for my condition
 Unemployed
 Retired
 Student
 Other

20. Other health problems may affect your treatment. Please check any of the following problems that apply to you:

<input type="checkbox"/> Arthritis (rheumatoid / osteoarthritis) <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Asthma <input type="checkbox"/> Chronic Obstructive Pulmonary Disease (COPD), acquired respiratory distress syndrome (ARDS) or emphysema <input type="checkbox"/> Angina <input type="checkbox"/> Congestive Heart Failure (or heart disease) <input type="checkbox"/> Heart Attack (Myocardial Infarction) <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Neurological Disease (such as Multiple Sclerosis or Parkinson's) <input type="checkbox"/> Stroke or TIA <input type="checkbox"/> Peripheral Vascular Disease <input type="checkbox"/> Headaches <input type="checkbox"/> Diabetes Types I and II <input type="checkbox"/> Gastrointestinal Disease (ulcer, hernia, reflux, bowel, liver, gall bladder)	<input type="checkbox"/> Visual Impairment (such as cataracts, glaucoma, macular degeneration) <input type="checkbox"/> Hearing Impairment (very hard of hearing, even with hearing aids) <input type="checkbox"/> Back Pain (neck pain, low back pain, degenerative disc disease, spinal stenosis) <input type="checkbox"/> Kidney, Bladder, Prostate or Urination Problems <input type="checkbox"/> Previous Accidents <input type="checkbox"/> Allergies <input type="checkbox"/> Incontinence <input type="checkbox"/> Anxiety or Panic Disorders <input type="checkbox"/> Depression <input type="checkbox"/> Other disorders <input type="checkbox"/> Hepatitis / AIDS <input type="checkbox"/> Prior Surgery <input type="checkbox"/> Prosthesis / Implants <input type="checkbox"/> Sleep dysfunction <input type="checkbox"/> Cancer
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21. Height: _____ ft _____ in.
 22. Weight: _____ lbs