Patient Intake Questionnaire

Patient Name: ______________________________________ **Date:** ____________________

What is the reason for your visit today? ____

Date of injury / onset of symptoms? ____

Since onset, are your symptoms (circle one): Improving Worsening Not Changing

Frequency of symptoms (circle one): Constant Intermittent/Daily Occasional

Date of surgery (if applicable): ______________________________

MEDICAL HISTORY

Do you currently have or do you have a past history of any of the following:

	Yes	No	If yes, please explain:
Cancer			
Diabetes			
High Blood Pressure			
Heart Disease			
Angina (Chest Pain)			
Pacemaker			
Stroke			
Osteoporosis			
Osteoarthritis			
Rheumatoid Arthritis			
Headaches			
Kidney Disease			
Seizures			
Urinary Incontinence			
Other			

MEDICATIONS: Please list all medications you are taking, including dosage, frequency, and route of administration. Include all prescriptions, over-the-counter, herbal/vitamin/mineral supplements. Please complete to the best of your ability. If you have a list of your current medications, please provide a copy to the receptionist.

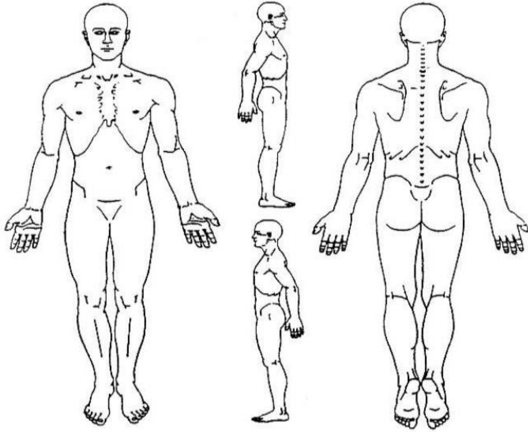
____ **List attached** ____ **I am not taking any medications, vitamins, or supplements**

Medication Name	Dosage	Frequency	Route of Administration (oral, cream, etc.)
		1 2 3 4 x/day PRN	
		1 2 3 4 x/day PRN	
		1 2 3 4 x/day PRN	
		1 2 3 4 x/day PRN	
		1 2 3 4 x/day PRN	
		1 2 3 4 x/day PRN	

Do you have any allergies? Y / N

If yes, please explain: ____

Please indicate below where your symptoms are located:



Key: Use symbol(s) below to mark area(s) of discomfort

Numbness: ==========

Pins/Needles: 0000000000

Stabbing Pain: ////////////////

Burning Pain: XXXXXXXX

Past Surgical History

Spine	Y / N	Date: ____________
Shoulder	Y / N	Date: ____________
Knee	Y / N	Date: ____________
Hip	Y / N	Date: ____________
Ankle	Y / N	Date: ____________
Hand	Y / N	Date: ____________

Other Surgeries:

____

____

____

____

Are you currently pregnant? Y / N

Current Pain Rating (circle all that apply):

Burning	Throbbing
Sharp	Shooting
Dull	Stabbing
Tight	Tingling
Numb	Other __________

Have you had any of the following diagnostic, medical, or rehabilitative services for your current symptom(s)/injury? (circle all that apply)

Chiropractic/Osteopath	Massage Therapy	Occupational Therapy	Physical Therapy
Neurologist	Orthopedist	Injection	EMG/NCV
CT Scan	MRI	X-rays	Other ___________________________

Please complete the following per CMS compliance guidelines.

Tobacco Use

Non-tobacco user _____

Current tobacco user: _____ Cigarettes _____ Smokeless tobacco _____ Cigars _____ Vape

Past tobacco user _____ Quit _____ months/years ago

Fall Risk

Have you had any falls in the past year? Y / N

If yes, how many? _____

If yes, any injury as a result of a fall? Y / N

Social History (PHQ-2 / EASI)

Do you have an active/current diagnosis of depression? Y / N **If yes**, skip the next two questions.

	Not at all (0)	Several Days (1)	More than half of the days (2)	Nearly every day (3)
1. During the past month, have you often been bothered by feeling down, depressed, or hopeless? (please circle one)	Not at all (0)	Several Days (1)	More than half of the days (2)	Nearly every day (3)
2. During the past month, have you often been bothered by little interest or pleasure in doing things? (please circle one)	Not at all (0)	Several Days (1)	More than half of the days (2)	Nearly every day (3)

Social History Continued . . .

1. Have you recently relied on people for any of the following: bathing, dressing, shopping, banking, or meals (prior to onset of symptoms, surgery, or injury)? Y / N
2. Has anyone prevented you from getting food, clothes, medication, glasses, hearing aides or medical care, or from being with people you wanted to be with? Y / N
3. Have you been upset because someone talked to you in a way that made you feel shamed or threatened? Y / N
4. Has anyone tried to force you to sign papers or to use your money against your will? Y / N
5. Has anyone made you afraid, touched you in ways that you did not want, or hurt you physically? Y / N

I certify to the best of my knowledge that the above information is complete and accurate.

______________________________ ______________________________

Patient/Parent/Guardian Signature **Date**

For Office Use Only

Patient Intake Questionnaire Reviewed By: ______________________________

Date Reviewed: ______________________________

Height: _________ Weight: ________ BMI: ___________ **NORMAL BMI** ≥ 18.5 and <25 kg/m2

PHQ-2 Score: __________ if score is 3+, refer to PCP

EASI Scoring: A response of "yes" to one or more of questions 2 through 6 indicates a need for further assessment. **Question 6**: Does the patient have poor eye contact, withdrawn nature, malnourishment, hygiene issues, cuts, bruises, inappropriate clothing, or medication compliance issues present on today's evaluation or within the past 12 months?