Patient INTAKE Survey

Upper Body

Neck, Cranium/Mandible, Thoracic Spine, Ribs

Patient Identification Number	**Survey Date** MM DD YYYY	**Payer Source**
Please select Patient Proxy, If applicable Spouse ☐ Other Family ☐ Caregiver ☐ Other ☐	**Primary Clinician**	
Care Type	**Body Part** **Multiple Sites** ☐	**Impairment Category** **Multiple Categories** ☐
Patient Name (Last Name, First Name)	**Date of Birth** MM DD YYYY	**Sex** **Male** ☐ **Female** ☐

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**
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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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:

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

21. Height: ________ ft _________in.

22. Weight: __________ lbs

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