



PT / OT Intake Questionnaire

CHRISTUS Good Shepherd Health System 700 E. Marshall Ave., Longview, Texas 75601

Date: _____

WELCOME TO OUR CLINIC. To assist in your care, please fill out or circle the answers as best you can.

NAME: _____ DOB: _____ AGE: _____ Sex: ☐ Male ☐ Female

Primary Language: _____ English Understood ☐ YES ☐ NO Interpreter Needed: ☐ YES ☐ NO

Describe why you are here. Your injury, surgery or onset of symptoms: _____

Date of Surgery: _____ Date of Injury: _____

Circle any **PREVIOUS TESTS** you have received: X-RAY / MRI / CT SCAN / NCV / EMG / Other: _____
Results: _____

Previous Physical Therapy / Occupational Therapy / Speech Therapy in the past 60 days? ☐ YES ☐ NO

Setting goals is necessary to help with your treatment and justify medical need. Your input is essential to help set your goals.

Recreation or Sports that you would like to return to following your therapy: _____

Please list any activities that you are currently unable to do because of your injury/illness: _____

Please state your goals for therapy: _____

EDUCATION: Highest grade completed (circle one): 1 2 3 4 5 6 7 8 9 10 11 12

- ☐ Some college/technical school ☐ College Graduate ☐ Graduate school / Advanced Degree

EMPLOYMENT:

____ Working (full-time / part-time) outside the home ____ Student
____ Working (full-time / part-time) inside the home ____ Homemaker
____ Retired ____ Disabled (reason): _____
____ Unemployed ____ Work restriction: _____

Occupation: _____

Work related injury? ☐ YES ☐ NO Recreational/sports Injury: ☐ YES ☐ NO Auto Accident injury? ☐ YES ☐ NO

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Have you ever been diagnosed with having any of the following?

- | | | |
|--|--|---|
| ☐ Asthma | ☐ Diabetes | ☐ Osteoporosis/Ostopenia |
| ☐ Alzheimer's/Dementia/memory loss | ☐ Fibromyalgia | ☐ Pacemaker |
| ☐ Anxiety/Depression Disorder/Bipolar Disorder / Schizophrenia | ☐ Fractures | ☐ Parkinson's Disease |
| ☐ Arthritis: OA/RA/Deg. Joint | ☐ GERD/Reflux | ☐ Peripheral Neuropathy/Peripheral Vascular Disease |
| ☐ Cancer, if yes, what kind _____ | ☐ Hearing Loss | ☐ Psoriasis |
| ☐ Chemical Dependency | ☐ Hepatitis | ☐ Pulmonary Embolism/Blood Clots/ DVT |
| ☐ Heart Problems: CHF/CAD | ☐ High blood pressure | ☐ Seizures/Epilepsy |
| ☐ Stroke/CVA / TIAs | ☐ Incontinence | ☐ Systemic Lupus Erythematosus |
| ☐ COPD/ Emphysema | ☐ Kidney Disease | ☐ Tuberculosis |
| | ☐ MRSA / Cdiff / VRE / HIV | ☐ Vision Problems |
| | ☐ Multiple Sclerosis | |
| | ☐ Muscular Dystrophy | |

Other: _____

Surgical History: _____

In the last year have you had any of the following symptoms?

- | | | | |
|--|--|---|---|
| ☐ Blackouts | ☐ Difficulty talking | ☐ Hearing Problems | ☐ Pain at night |
| ☐ Bowel/Bladder problems | ☐ Dizziness | ☐ Loss of appetite | ☐ Ringing in ears |
| ☐ Chest Pain | ☐ Fatigue | ☐ Loss of balance | ☐ Shortness of breath |
| ☐ Coordination Problems | ☐ Fever/Chills | ☐ Nausea/Vomiting | ☐ Urinary Problems |
| ☐ Difficulty Sleeping | ☐ Frequent Itching | ☐ Night sweats | ☐ Vision problems |
| ☐ Difficulty Swallowing | ☐ Headaches | ☐ Numbness/Weakness | ☐ Weight loss/gain |

Have you fallen within the past 6 months? ☐ YES ☐ NO How many times? _____ Were you injured? ☐ YES ☐ NO

Do you live in a:

☐ Single story / 2 story home	☐ Mobile home
☐ Private Apartment	☐ Assisted Living/Group Home
☐ Homeless	

Do you live alone? ☐ YES ☐ NO (with whom?) _____

Are the people you live with able to help you? ☐ YES ☐ NO

Does your home have:

- | | | |
|--|---------------------------------|--|
| ☐ Stairs with railing | ☐ Ramps | ☐ Uneven terrain/surfaces |
| ☐ Stairs without railing | ☐ Elevators | ☐ Assistive Devices: Commode / bath bench / grab bar |

Do you use any of the following:

- | | |
|------------------------------------|---|
| ☐ Walker | ☐ Motorized Chair |
| ☐ Wheelchair | ☐ Hearing Aids |
| ☐ Brace/Splint | ☐ No assistive device |
| ☐ Cane | ☐ Other: _____ |

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MARK YOUR PAIN on the diagram to the right

Front

Back

PLEASE RATE your pain: ("0" = no pain, "10" worst pain possible)

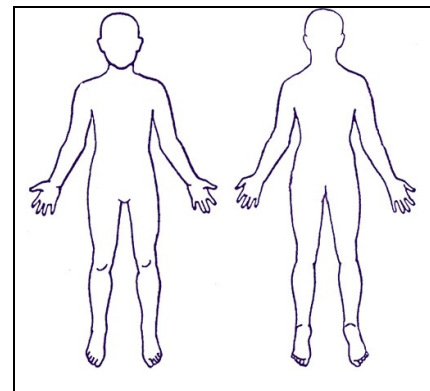
0	1	2	3	4	5	6	7	8	9	10
MINIMAL	MILD				MODERATE		SEVERE	SEVERE	VERY POSSIBLE	WORST

Rate pain at rest _____ Rate Pain at Least Level _____

Rate pain at worst level _____ Rate pain with activity _____

Has your pain been present for more than 6 weeks: ☐ YES ☐ NO

Pain medication: None – Prescription - Non-Prescription



What makes your pain worse? _____

What makes your pain better? _____

Describe your pain (circle any): aching - burning - constant - contracting - cramping - crushing - discomfort - dull - heavy - intermittent - numbness - penetrating - pins and needles - pounding - pressure - radiating - sharp - shocking - sore - spasm - squeezing - stabbing - tender - throbbing - tightness - tingling - unable to describe –

Other: _____

How long does your pain last (circle): constant/rarely/once a week/several days/occasionally/ Other: _____

Does your pain affect your sleep? ☐ YES ☐ NO

In general: Not changing - gradually worsening - gradually improving - rapidly worsening - rapidly improving

What is your pain goal: _____

Did you / Are you: ☐ Use tobacco ☐ Drink Alcohol ☐ Sensitive to latex

WOMEN: Are you pregnant or think you might be pregnant? YES / NO

Please list any customs, religious beliefs, wishes that might relate to your care: _____