Intake Questionnaire **Todays Date:**

Name:	Are you currently working? □ Yes □ No
	If no, what was the last day you worked?
Date of Birth:	If yes, do you have any light duty restrictions? □ Yes □ No Please list restrictions:
Referring Physician:	
Occupation:	Is this a work-related Injury? □ Yes □ No
	Have you had prior surgery on this joint? □ Yes □ No
Are you: □ Right-Handed □ Left-Handed	Joint Replacement? □ Yes □ No

History of Current Injury or Problem

When did the symptoms start or injury occur?
Please describe your injury or problem:
Please list any treatments or tests that you have had for this injury or problem?
Injections:
Assistive Devices/Braces/Orthotics:
Physical Therapy: □ Yes □ No If so, where did you receive care?

Review of Symptoms (check all boxes that apply to you)

Constitution	**Eyes**	**Respiratory**	**Endocrine/Hematological**
□ Fever	□ Blindness	□ Cough	□ Easy Bruise/bleed
□ Chills	□ Visual Disturbance	□ Apnea	□ Frequent Infections
□ Weight Loss	**Cardiovascular**	□ Shortness of Breath	**Neurological**
□ Malaise/Fatigue	□ Chest Pain	**Urinary**	□ Numbness
□ Weakness	□ Palpitations	□ Frequency	□ Tingling
Skin	□ Leg Cramps with Exercise	□ Urgency	□ Seizures
□ Rash	□ Leg Swelling	□ Blood in Urine	□ Loss of Consciousness
□ Dry Skin	□ Fainting	□ Incomplete emptying	**Psychiatric**
□ Itching	**Gastrointestinal**	**Musculoskeletal**	□ Depression
□ Wound	□ Heartburn	□ Falls	□ Nervous/Anxious
Head, Neck, Throat	□ Nausea	□ Neck Pain	□ Memory Loss
□ Headaches	□ Vomiting	□ Back Pain	
□ Hearing Loss	□ Diarrhea	□ Joint Swelling	
□ Sore Throat	□ Constipation	□ Muscle Spasm	
□ Dental Problems	□ Blood in Stool	□ Muscle Cramps	