CHRISTUS® GOOD SHEPHERD
Medical Center - *Longview*
Physical Therapy and Sports Medicine
Occupational Therapy

Intake Questionnaire

WELCOME TO OUR CLINIC: **Date:**____________
In order to serve you promptly, please complete the following questions:

1. Patient's Name (Last & First)____________________________________ **2. Age:**________

3. Race: ☐ Asian ☐ Black ☐ Hispanic ☐ White ☐ Other: ________________

4. Sex: ☐ Female ☐ Male

5. Language: What language do you speak most:____________
☐ English understood.
☐ Interpreter needed.

6. Cultural/ Religious: Do you have any customs or religious beliefs/wishes that might affect your care?____________
____

7. 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

8. Employment : ☐ Working full-time outside home ☐ Working part-time outside home ☐ Retired
☐ Working full-time from home ☐ Working part-time from home ☐ Unemployed
☐ Homemaker ☐ Student

Occupation:________________________________ Work related injury: ☐ Yes ☐ No

9. Where do you live? ☐ Private Home
☐ Private Apartment
☐ Assisted Living/ Group Home
☐ Homeless
☐ Long term care facility (nursing home)
☐ Hospice
☐ Other:________________

10. With whom do you live?
☐ Alone
☐ Spouse Only
☐ Spouse and other(s)
☐ Child (not spouse)
☐ Relative(s)
☐ Group setting
☐ Personal Care Attendant
☐ Other:__________

11.Does your home have:
☐ stairs, no railing
☐ stairs, railing
☐ ramps
☐ elevator
☐ uneven terrain/surfaces
☐ assistive devices(ex. Bathroom)
☐ commode ☐ bath bench ☐ grab bars
☐ other:________________
☐ other obstacles:____________

12. Do you use: ☐ cane
☐ walker or rolling walker
☐ manual wheelchair
☐ motorized wheelchair
☐ other:____________
☐ no assistive device

13. Health Habits: a) Smoking:
Currently smoke tobacco? ☐ Yes ☐ Cigarettes # of pack per day________
☐ Cigars # per day________
☐ How many years have you smoked? ______
☐ No

Smoked in past? ☐ Yes; year quit __________ ☐ No

b) Alcohol: How may days per week do you drink beer, wine, or other alcoholic beverages? __
If one beer, one glass of wine or one cocktail equals one drink; how many drinks do you have on an average day?____________

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14. Family History: (Indicate whether any family member has had)

- ☐ Heart disease
- ☐ Hypertension
- ☐ Stroke
- ☐ Diabetes
- ☐ Cancer
- ☐ Psychological disorder
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Other:________________

15. Medical History: (Indicate if you have / had)

- ☐ Arthritis
- ☐ Multiple Sclerosis
- ☐ Broken Bones
- ☐ Muscular Dystrophy
- ☐ Osteoporosis
- ☐ Parkinson's disease
- ☐ Blood disorders
- ☐ Seizures/Epilepsy
- ☐ Circulation problems
- ☐ Allergies
- ☐ Heart problems
- ☐ Thyroid problems
- ☐ High blood pressure
- ☐ Cancer
- ☐ Lung problems
- ☐ Tuberculosis
- ☐ Stroke
- ☐ Hepatitis
- ☐ Diabetes
- ☐ VRE / MRSA / Cdiff
- ☐ Hypoglycemia
- ☐ Kidney problems
- ☐ Head injury
- ☐ Repeated infections
- ☐ Depression
- ☐ Dizziness/ Vertigo
- ☐ Polio
- ☐ Migraines
- ☐ Stomach problems
- ☐ Skin diseases
- ☐ Pregnant/Pregnancy
- ☐ Other:____________________________

16. Within the past year, have you had any of the following symptoms? (check all that apply)

- ☐ Chest pain
- ☐ Difficulty sleeping
- ☐ Weight gain/loss
- ☐ Loss of appetite
- ☐ Pain at night
- ☐ Night sweats
- ☐ Fever/chills
- ☐ Shortness of Breath
- ☐ Dizziness
- ☐ Difficulty talking
- ☐ Difficulty swallowing
- ☐ Vision problems
- ☐ Blackouts
- ☐ Headaches
- ☐ Hearing problems
- ☐ Bowel problems
- ☐ Urinary problems
- ☐ Frequent itching
- ☐ Coordination problems
- ☐ Loss of balance
- ☐ Numbness/Weakness
- ☐ Fatigue
- ☐ Nausea/Vomitting
- ☐ Ringing in ears
- ☐ Other:____________________________

17. Current Condition/ Chief Complaint:

Reason for Visit:____________________________________ When did your symptoms begin:________

Have you ever had the problem(s) before? ☐ Yes ☐ No

What did you do for the problem(s)?____________________________________

Did the problem(s) get better? ☐ Yes ☐ No

What makes the problem worse?____________________________________

What makes the problem better?____________________________________

What is your goal for physical therapy/occupational therapy?____________________________________

____

Are you seeing anyone else for the problem(s)? (Check all that apply)

- ☐ Home Health
- ☐ Occupational therapist
- ☐ Speech therapist
- ☐ Chiropractor
- ☐ Orthopedist
- ☐ Cardiologist
- ☐ Dentist
- ☐ Pediatrician
- ☐ Primary care Physician
- ☐ Family practitioner
- ☐ Podiatrist
- ☐ Rheumatologist
- ☐ Massage therapist
- ☐ Neurologist
- ☐ Internist
- ☐ Osteopath
- ☐ Obstetrician/ gynecologist
- ☐ Acupuncturist
- ☐ Other:____________________

18. Other clinical tests: Within the last year, have you had any of the following tests? (Check all that apply)

- ☐ Angiogram
- ☐ Arthroscopy
- ☐ Biopsy
- ☐ Blood tests
- ☐ Bone scan
- ☐ Bronchoscopy
- ☐ CT scan
- ☐ Doppler ultrasound
- ☐ Echocardiogram
- ☐ Electroencephalogram(EEG)
- ☐ Electrocardiogram(ECG)
- ☐ Electromyogram(EMG)
- ☐ Mammogram
- ☐ MRI
- ☐ Myelogram
- ☐ Nerve conduction velocity
- ☐ Pap smear
- ☐ Pulmonary function test
- ☐ Spinal tap
- ☐ Stool tests
- ☐ Urine test
- ☐ X-rays
- ☐ Stress test (ex. treadmill, bicycle)
- ☐ Other:____