Patient INTAKE Survey

Upper Body

Neck, Cranium/Mandible, Thoracic Spine, Ribs

Staff Only

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 knowing whether you are having any difficulty with the activities listed below because of the problem for which you are currently seeking attention. Please provide an answer for each activity. If you do not perform an activity, you may select Not Applicable.

Today, how much does the affected body part for which you are seeking attention limit:	Limited a lot	Limited a little	Not limited at all	Not Applicable
1. VIGOROUS ACTIVITIES like running, lifting heavy objects, sports?				
2. Participating in recreation?				
3. MODERATE ACTIVITIES like moving a table or pushing a vacuum cleaner?				
4. Lifting or carrying items like groceries?				
5. Lifting overhead to a cabinet?				
6. Gripping or opening a can?				
7. Handling of small items such as a pen or coins?				
8. Feeding yourself?				
9. Getting in and out of bed?				
10. Bathing or dressing?				
11. Completeing your toileting?				

12. Please indicate the amount of pain you have had in the last 24 hours (Please circle Number):

No Pain 0 1 2 3 4 5 6 7 8 9 10 **Pain as bad as it can be**

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)
_____ Osteoporosis
_____ Asthma
_____ Chronic Obstructive Pulmonary Disease (COPD), acquired respiratory distress syndrome (ARDS) or emphysema
_____ Angina
_____ Congestive Heart Failure (or heart disease)
_____ Heart Attack (Myocardial Infarction)
_____ High Blood Pressure
_____ Neurological Disease (such as Multiple Sclerosis or Parkinson's)
_____ Stroke or TIA
_____ Peripheral Vascular Disease
_____ Headaches
_____ Diabetes Types I and II
_____ Gastrointestinal Disease (ulcer, hernia, reflux, bowel, liver, gall bladder)

_____ Visual Impairment (such as cataracts, glaucoma, macular degeneration)
_____ Hearing Impairment (very hard of hearing, even with hearing aids)
_____ Back Pain (neck pain, low back pain, degenerative disc disease, spinal stenosis)
_____ Kidney, Bladder, Prostate or Urination Problems
_____ Previous Accidents
_____ Allergies
_____ Incontinence
_____ Anxiety or Panic Disorders
_____ Depression
_____ Other disorders
_____ Hepatitis / AIDS
_____ Prior Surgery
_____ Prosthesis / Implants
_____ Sleep dysfunction
_____ Cancer

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