Patient INTAKE Survey
Medical / Neurological

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 Medical / Neurologic 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 (N/A).

How much does your health limit:	Limited a lot	limited a little	Not limited at all	N/A
1. Vigorous activities like running, lifting heavy objects, sports?				
2. Moderate activities like moving a table or pushing a vacuum cleaner?				
3. Lifting or carring items like groceries?				
4. Bending , kneeling or stooping?				
5. Climbing several flights of stairs?				
6. Climbing one flight of stairs?				
7. Walking more than a mile?				
8. Walking one block?				
9. Bathing or dressing?				
10. Going on vacation?				
11. Getting in and out of a chair?				
12. Walking around a room?				
13. Getting in and out of a bed?				

14. 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**

15. Indicate the number of surgeries for your primary condition ____0 ____1 ____2 +

16. How many days ago did this condition begin?

____0 - 7 ____8 - 14 ____15 - 21 ____22 - 90 ____91 - 6 mo. ____More than 6 mo.

17. Are you taking prescription medication for this condition? ____ Yes ____ No

18. Have you received treatments for this condition before? ____ Yes ____ No

19. 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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20. 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

21. 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

22. 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