MERITREHAB

PATIENT INTAKE QUESTIONNAIRE

Date: ______________________________

Name: ______________________________

Chief Complaint: ______________________________

What are your symptoms? ______________________________

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When did your symptoms begin? ______________________________

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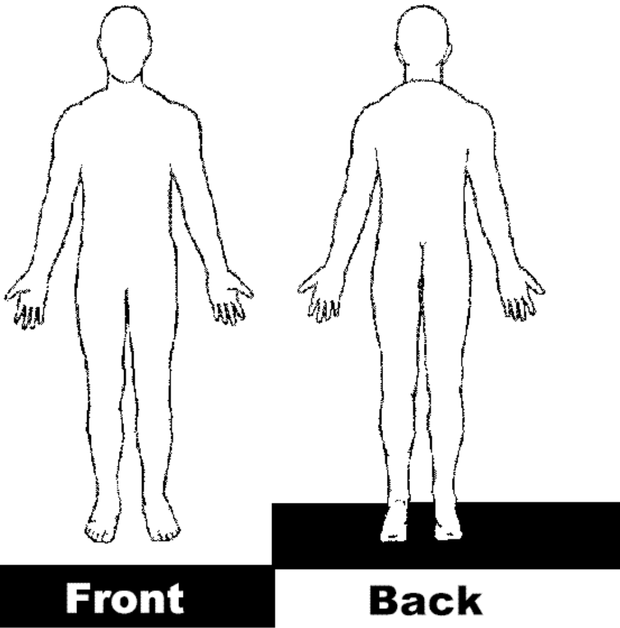
WHERE IS YOUR PAIN?

Please mark the body diagram to indicate the location of your pain: Numbness = = = = = =
Sharp/Stabbing pain X X X X X
Burning ^^^^^^^^^^^^^



RATE YOUR PAIN

Please circle the level of your pain

1 2 3 4 5 6 7 8 9 10
(No pain) (Severe pain)

1. Since onset, are your symptoms getting:
   Better Worse Staying the same
2. Are your symptoms
   Constant Intermittent

If intermittent: How often do they occur? ______________________________

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How long do they last? ______________________________

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When do they get worse? ______________________________

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When are they best? ______________________________

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3. As the day progresses, do your symptoms:
   Increase Decrease Stay the same

4. Please list any activities you can't do now as as a result of your injury/symptoms: ______________________________

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5. Have you seen any of the following during the past three months?

Medical Doctor (MD)	Physical Therapist (PT)
Acupuncturist	Osteopath (DO)
Chiropractor (DC)	Massage Therapist
Dentist	Naturopathic Doctor (ND)
Oriental Medicine Doctor	Other ______________

6. Have you had any of the following tests performed for this problem?

   X-ray MRI CT Scan Bone Scan
   Arthrogram Lab Tests Other ______________

Results: ______________________________

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7. Please list any prescription medications you are currently taking (pain pills, injections and/or skin patches, etc.): ______________________________

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8. Do you exercise on a regular basis? Yes No
   If yes, what type of exercise do you do? ______________

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PAST MEDICAL HISTORY

Please list any illness, medical & surgical history (ie: diabetes, high blood pressure, etc.) ______________________________

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What goals would you like to achieve from therapy?

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