McLaren
GREATER LANSING

REHAB SERVICES INTAKE QUESTIONNAIRE

Name:____________________ **Age:**_______ **Ht:**_______ **Wt:** _______

Why you are seeking therapy? ____________________

How long ago did this episode start? *(Be as specific as possible)* ____________________

Briefly describe how your problem occurred? ____________________

____

EMPLOYMENT:

☐ Full-time ☐ Part-time ☐ Student
☐ Retired ☐ Disabled ☐ Other ____________

Occupation:____________ Employer:____________ Length of employment: ____________

Are you currently working? ☐ Yes ☐ No

Handedness: ☐ Left ☐ Right
Glasses: ☐ Yes ☐ No
Hearing loss: ☐ Yes ☐ No
Hearing aids: ☐ Yes ☐ No

Is there any legal action related to this injury? ☐ Yes ☐ No

HOME STATUS/FUNCTIONAL LEVEL:

Lives (with) ☐ Alone ☐ Spouse ☐ Family____________ ☐ Friend(s)
Home ☐ 1-story with/without basement ☐ 2-story home with/without basement
☐ Apartment with/without elevator ☐ mobile Home ☐ Other ____________
Maximum # of stairs to walk at any one time in home_________ Are there handrails? ☐ Yes ☐ No

Are you currently receiving ANY home health services like nursing, lab, psychiatric care, OT/PT/ST, etc.? ☐ Yes ☐ No

MEDICAL HISTORY (Please check each condition that relates to you)

☐ Pacemaker/defibrillator
☐ Osteoporosis, osteopenia
☐ Arthritis (osteo, rheumatoid)
☐ Bleeding tendencies
☐ Cancer (type____________)
☐ High blood pressure
☐ Diabetes (type___________)
☐ Stomach disorders
☐ Liver disorder
☐ Bowel/bladder issue
☐ Thyroid disease
☐ Kidney disease
☐ Heart disease/attack
☐ Skin disease
☐ HIV (+)
☐ Mental health issues
☐ Lung disease/asthma
☐ Seizure disorder
☐ Circulation problems
☐ Unexplained wt. gain/loss
☐ Metal implants
☐ Stroke
☐ Pregnant # of months ____________
☐ Frequent nausea/vomiting
☐ Neurological disorder:____________
☐ Other ____________

Any surgeries that may be associated with your current condition? ☐ No ☐ Yes____________

Please list and date____________________

744-09 REV. 9/06

680a

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Allergies	**Yes**	**No**		**Yes**	**No**
Drug	☐	☐	Food	☐	☐
Environmental	☐	☐	Tape	☐	☐
			Latex	☐	☐

List all current medications including over-the-counter types *(If you have a list we will photocopy it):*

____

____

How frequently are you using pain medication for this condition?
☐ Every 3-4 hrs ☐ Daily ☐ Weekly ☐ Intermittent/As needed ☐ Do not use
☐ Other______________________

What are you using for pain medication? ______________________________

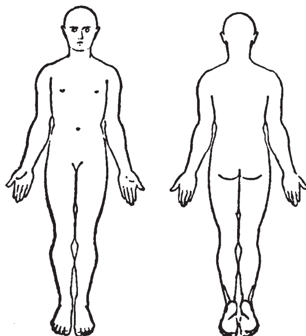
Do You? ☐ Smoke *How much?*_________ ☐ Drink alcohol *How much?*_________ ☐ Caffeine *How much?*_________

Have you had any of the following for this condition? (If yes, state results)
☐ None ☐ Bone scan__________ ☐ Doppler/Ultrasound
☐ X-rays__________ ☐ Arthrogram__________ ☐ Other____________________
☐ MRI__________ ☐ EMG__________
☐ CT scan__________ ☐ Diagnostic arthroscopy *RESULTS:*____________________

Previous treatment(s) for this condition:
☐ None ☐ Injections ☐ Hospitalization
☐ Medication ☐ Acupuncture ☐ Pain Clinic
☐ O.T./P.T. ☐ Surgery ☐ Other____________________
☐ Chiropractor ☐ Splinting/Taping/bracing
☐ Massage therapy ☐ TENS unit
☐ Exercise ☐ Traction

Please circle those treatments that help you.

Rate your pain on a scale of 0-10 (0=no pain, 10=worst pain) current____ at best____ at worst____



Please mark symptoms on the body diagram
X=areas of pain O=areas of numbness/tingling

Are your symptoms getting? *(Check one)*
☐ Better ☐ Worse ☐ Not Changing

Are your symptoms generally?
☐ Better/worse in morning ☐ Better/worse in afternoon ☐ Better/worse at night
☐ Better/worse while sleeping ☐ Better then worsens as the day progresses

Pain behavior:
☐ Constant ☐ Burning ☐ Intermittent sharp pain
☐ Intermittent ☐ Numbness tingling ☐ Throbbing
☐ Constant dull ☐ Stabbing ☐ Other________________________

744-09 REV. 9/06

McLaren
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Adaptive/Assistive Equipment Owned:

☐ None
☐ Cane
☐ Crutches
☐ Walker
☐ Wheeled Walker
☐ Tub seat with/without back
☐ Transfer tub bench
☐ Grab bars
☐ Bedside commode
☐ Lift chair
☐ Toilet riser with/without arms
☐ Reacher
☐ Sock aide
☐ Long handle sponge
☐ Handheld shower
☐ Wheelchair
☐ Hospital bed
☐ Other___________________________

Prior to the current problem, did you walk using a device?

☐ No ☐ Cane ☐ Crutches ☐ Standard Walker ☐ Rolling Walker ☐ Other_________________________________

Were you independent with your basic daily self care prior to this episode?

☐ Yes ☐ No ☐ Had help with____

Check each box (✓) as it applies to the activity
(**X**) Activities that you have had to stop doing due to this current problem
(**O**) Activities that cause you pain

Activity	X	O	Activity	X	O	Activity	X	O
Sitting			Getting item from floor			Open/close doors		
Standing			Lifting to knee level			Working at sink level		
Walking			Lifting to waist level			Mowing/yard work		
Lay on back			Lifting to chest level			Writing		
Lay on side			Lifting item overhead			Computer work		
Lay on stomach			Dressing tasks			Starting the car		
Sleep			Bathing tasks			Opening container/jars		
Vacuum or housekeeping tasks			Shave legs/under arms			Fastening undergarments		
Laundry tasks			Wash/comb/style hair			Carrying items while walking		
Put on socks and shoes			Go up/down stairs			Repetitive lifting or reaching		

Number of falls in the last month?______ In the last year?______

What is it that you would like to do that you're not currently doing because of your problem?

____

History reviewed with patient ☐ Yes ☐ No Additional Information ______________________________

____

____

Therapist Signature____ *Office use only*

680

744-09 REV. 9/06