

Name: _____ Age: _____ Today's Date: _____

Describe the problem that brings you to therapy: _____

Date problem began: _____

How did your problem or injury occur? _____

Have you had treatment for this problem? (If so, please describe) _____

Please list any healthcare professional whose care you're currently under (i.e. Medical Doctor, Osteopath, Dentist, Psychiatrist/Psychologist, Chiropractor, etc.) _____

Before this problem began, how well were you functioning? _____

Since then, has your problem: Worsened Improved Stayed same

What do you hope to achieve as a result of this treatment? _____

Do you have pain? YES NO → If yes, please indicate areas and type of pain with the following symbols ON THE BODY CHART BELOW.

SHARP
XXXX

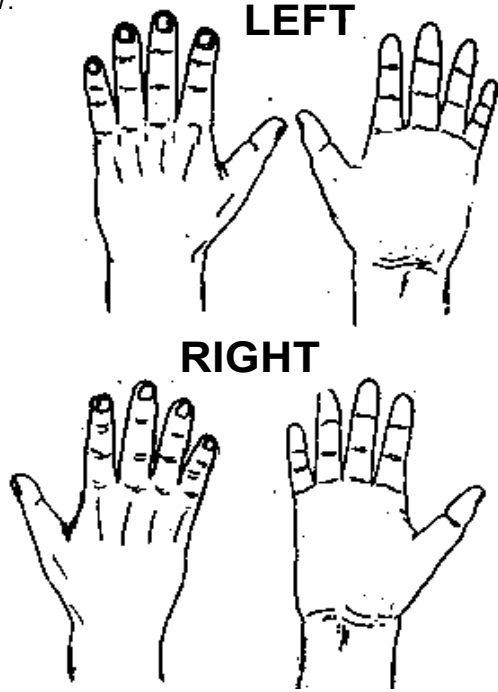
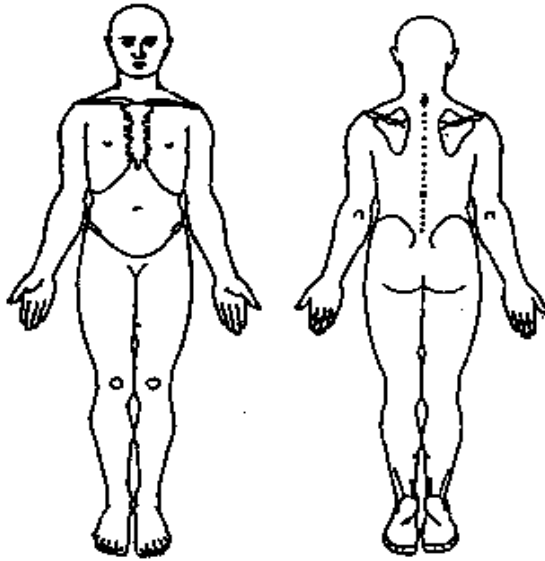
DULL
OOOOOO

ACHING
✓✓✓✓✓✓

NUMBNESS
□□□□□

TINGLING
●●●●●●●●

BURNING
// // // // //



Is pain **constant** or does it **come and go**? (circle one)

What activities **INCREASE** pain/symptoms? _____

What activities **DECREASE** pain/symptoms? _____

Please rate your pain on the following pain scale: (Circle the number.)

0 1 2 3 4 5 6 7 8 9 10
 (none) (Severe)

Have you had any previous orthopedic problems? If yes, specify: _____

What is your occupation? _____

What activities does your work require? (ex: lifting, prolonged sitting, standing, etc.) _____

Are you currently working? YES NO If not, when was your last day of work? _____

Living arrangement: Alone With others _____

Describe what you do to keep physically fit: _____



Olathe Medical Center

20333 West 151st Street
Olathe, Kansas 66061



OUTPATIENT PHYSICAL & OCCUPATIONAL THERAPY INTAKE QUESTIONNAIRE

Page 1 of 2

5.31.2007; Rehab

O.M.C. No. 1082

PLACE
PATIENT LABEL
HERE

During the past month have you been feeling down, depressed, or hopeless? YES NO
 During the past month have you been bothered by having little interest or pleasure in doing things? YES NO
 Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? YES NO

Please indicate (X) which of the following activities you have difficulty with or are compensating for:

___ Dressing ___ Hygiene (bathing, toileting, grooming) ___ Household activities ___ Sleeping
 ___ Walking ___ Skills with Dominant Arm ___ Work Activities ___ Sitting ___ Other _____

Past Medical History: Do you have ANY previous history of the things listed below?

CONDITIONS:	YES	NO	CONDITIONS:	YES	NO
High Blood Pressure			Pacemaker		
Heart Condition			Seizures		
Stroke(s)			Cancer		
Metal Implants			Shortness of Breath		
Diabetes			Persistent Night Pain		
Dizziness			Frequent/Severe Headaches		
Light Headedness			Unexplained Weight Loss		
Excessive Fatigue			Past or Current Bowel/Bladder dysfunction		
Broken Bones (fractures)			Gynecological Issues		
Fibromyalgia			Vaginal/Cesarean Birth (Number: _____)		
Arthritis			<input type="checkbox"/> Did you have any back pain with your pregnancy or after childbirth?		
Psychiatric Illness					
Surgeries, Hospitalizations, or further detail on Past Medical History (list any with dates, if possible):					
Are you latex sensitive? <input type="checkbox"/> YES <input type="checkbox"/> NO					
List any other allergies.					
What is your learning preference? <input type="checkbox"/> Written <input type="checkbox"/> Verbal <input type="checkbox"/> Video <input type="checkbox"/> Other:					
Do you have an Advanced Directive? <input type="checkbox"/> YES <input type="checkbox"/> NO					
If yes, can you provide it? <input type="checkbox"/> YES <input type="checkbox"/> NO If no, do you need more information? <input type="checkbox"/> YES <input type="checkbox"/> NO					

Are you currently receiving any home health services? YES NO

Are you pregnant now or is there a chance you could be? YES NO

Have you taken steroids for a prolonged period of time? YES NO

List any medicines you are currently taking (including herbals): _____

Have you had any tests in the past 6 to 12 months? (X-Ray, CT Scan, MRI, EMG, ECG, etc) _____

Have you recently noted (**within the past 3 months**):

Weight loss/gain	YES	NO	Weakness	YES	NO
Nausea/Vomiting	YES	NO	Fever/chills/sweats	YES	NO
Dizziness/lightheadedness	YES	NO	Numbness or tingling	YES	NO
Fatigue	YES	NO			

In the space below, please tell us anything else you think your therapist will need to know: _____



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Page 2 of 2

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