Ferry County Rehabilitation Services
Patient Intake Questionnaire

Name_____ **Date** _____ **Age** _____ **Ht** _____ **Wt** _____

Diagnosis _____ **Doctor** _____ **Date of injury** _____

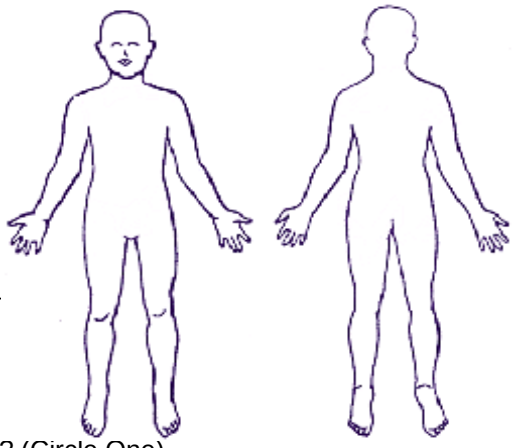
Occupation _____ **Are you working now?** _____ **Rt / Lt handed?**

What is the primary problem? _____

How did the pain start?

- o Sudden
- o Gradual
- o Lifting
- o Pulling
- o Twisting
- ○ Injured at work
- ○ Auto accident
- ○ Surgery
- ○ No apparent cause

Color in diagram where it hurts:



Since the onset, has your pain gotten: Worse? Better? Stayed the same?

Quality of pain?

- o Sharp
- o Shooting
- o Burning
- o Cramping
- ○ Aching
- ○ Throbbing
- ○ Dull
- ○ Other _____

Intensity (pain scale) 1 2 3 4 5 6 7 8 9 10

Current _____ Worst _____ Best _____

Does the pain Increase, Decrease or have No Change while doing the following? (Circle One)

Increase=I **Decrease=D** **No Change=N**

I / D / N	Lying down	I / D / N	Pain Pills
I / D / N	Sitting	I / D / N	Manipulation
I / D / N	Standing	I / D / N	Injections for pain
I / D / N	Walking	I / D / N	Muscle relaxant pills
I / D / N	Heat	I / D / N	Aspirin/anti-inflammatory meds
I / D / N	Cold	I / D / N	Massage
I / D / N	Exercises	I / D / N	Mornings
I / D / N	End of Day	I / D / N	Sleep/Night
I / D / N	Movement	I / D / N	Other
I / D / N	Absolutely nothing changes the pain?		

Have you had any of the following treatments?

- o X-rays
- o MRI
- o CT
- o Bone scan
- o EMG
- o Injections
- ○ Myelogram
- ○ Arthrogram
- ○ Electrocardiogram
- ○ Bone density
- ○ Blood/urine tests
- ○ Other

○ Other Where? _____ When? _____

Have you ever had a similar problem? Yes / No

- o Describe: _____
- o How was this managed or treated? _____

Do you smoke cigarettes: Yes / No

Do you have problems with other joints? _____

How would you describe your general health: _____

How long can you do the following without changing positions?

Sit _____ (minutes/hours) Stand _____(minutes/hours) Walk _____(minutes/hours)

List three activities or tasks that you want physical therapy to help you improve the most? (Please be specific eg: drive more than 15 minutes, walk an hour, vacuum the entire house, etc)

(1) _____
(2) _____
(3) _____

Self assessment of health: If 100% is how well you felt before the onset of this problem, what percent would you rate yourself now? _____%

Hobbies/interests or other information that would be helpful for us to know:

How would you like to be notified of your next appointment?

Existing Conditions

Allergies	___ Yes	___No	Headaches (Chronic)	___ Yes	___No
Anemia	___ Yes	___No	Hepatits	___ Yes	___No
Anxiety	___ Yes	___No	High Blood Pressure	___ Yes	___No
Arthritis	___ Yes	___No	HIV/Aids	___ Yes	___No
Asthma	___ Yes	___No	Incontinence	___ Yes	___No
Autoimmune Disorder	___ Yes	___No	Kidney Problems	___ Yes	___No
Cancer	___ Yes	___No	Metal Implants	___ Yes	___No
Cardiac Condtions	___ Yes	___No	Multiple Sclerosis	___ Yes	___No
Cardiac Pacemaker	___ Yes	___No	Muscular Disease	___ Yes	___No
Chemical Dependency	___ Yes	___No	MRSA	___ Yes	___No
Circulation Problems	___ Yes	___No	Osteoporosis	___ Yes	___No
Currently Pregnant	___ Yes	___No	Rheumatoid Arthritis	___ Yes	___No
Depression	___ Yes	___No	Seizures	___ Yes	___No
Diabetes	___ Yes	___No	Speech Problems	___ Yes	___No
Dizzy Spell	___ Yes	___No	Strokes	___ Yes	___No
Emphysema/ Bronchitis	___ Yes	___No	Thyroid Disease	___ Yes	___No
Fibromyalgia	___ Yes	___No	Tuberculosis	___ Yes	___No
Fractures	___ Yes	___No	Vision Problems	___ Yes	___No
Gallbladder Problems	___ Yes	___No			

If you answered yes to any of the above, feel free to include any details you would like your therapist to know:

_____
_____
_____

Fall History

Injury as a result of a fall in the past year? _____Yes _____No
Two or more falls in the past year? _____Yes _____No

Surgical History (or attach list, if available)

Body Region:	_____	Surgery Type	_____	Date	_____
Body Region:	_____	Surgery Type	_____	Date	_____
Body Region:	_____	Surgery Type	_____	Date	_____
Body Region:	_____	Surgery Type	_____	Date	_____
Body Region:	_____	Surgery Type	_____	Date	_____

Current Medications (or attach list, if available)

Oral? Intravenous? Other?

Drug _____ Dosage: _____ Frequency: _____ Route: _____ Reason Taking: _____
Drug _____ Dosage: _____ Frequency: _____ Route: _____ Reason Taking: _____
Drug _____ Dosage: _____ Frequency: _____ Route: _____ Reason Taking: _____
Drug _____ Dosage: _____ Frequency: _____ Route: _____ Reason Taking: _____
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Drug _____ Dosage: _____ Frequency: _____ Route: _____ Reason Taking: _____
Drug _____ Dosage: _____ Frequency: _____ Route: _____ Reason Taking: _____

FERRY COUNTY PUBLIC HOSPITAL DISTRICT #1

Rehab Therapy **509-775-8400** **fax: 509-775-8401**

PT/OT GUIDELINES FOR SCHEDULING AND ATTENDANCE

Per Ferry County Public Hospital District Policy, the PT/OT Department will follow these guidelines for scheduling:

If a patient is unable to be present for a scheduled appointment, they must call the office at 509-775-8400 no later than 4:00 PM the day before their appointment to cancel

_____
Patient Initial

If a patient does not cancel their appointment, and does not appear for their appointment, this is considered a No-Show

_____
Patient Initial

If a patient has two No-Shows they may be discharged from treatment and referred back to their physician

_____
Patient Initial

If attendance appears to be a problem, the department manager will discuss this with the patient to determine a workable treatment schedule, or if discharge is appropriate

_____
Patient Initial

NOTE: This signed policy will be scanned into the patient's chart and made of record

Contact Information:

O Telephone _____
Is it OK to leave a message on your answering machine? _____
Is it OK to leave a message with the person that answers the phone? _____

O Text _____
Cell Number

Patient signature: _____ Date: _____

Updated 10/16