Clinical Intake Questionnaire

Patient Name_____ Today's Date: _____

Age _____ □Right hand dominant □Left hand dominant Occupation _____

What brings you in today? Side: R□ L□ Both□ Body Part _____

When did this problem begin? _____

How did it start? □ injury □Car accident □work injury □out of the blue □other _____

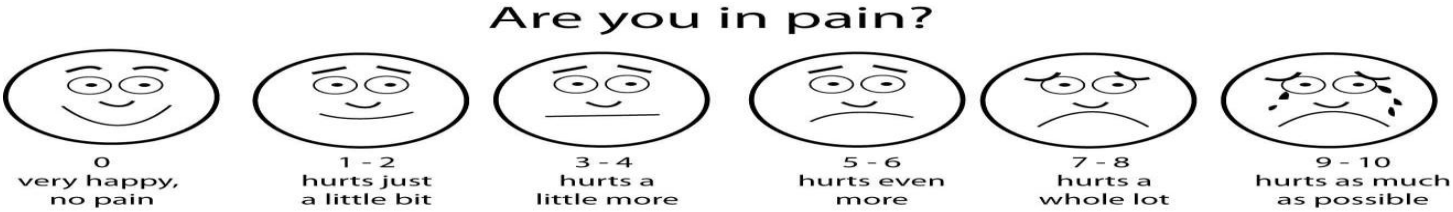
Where did your problem begin? □ work □home □gym □other _____

What are your symptoms? □ pain □numbness □swelling □other _____

What type of pain are you having? □ sharp □dull □other _____

Does your pain radiate? □no □yes, where? _____

How bad is the pain on a scale of 1-10?



When do your symptoms occur? □ day □night □all of the time □other _____

What is the frequency of your pain? □constant □fluctuating □improving □other _____

Does the pain wake you up at night? □no □yes _____

Does anything make it worse? □no □yes _____

Does anything make it better? □no □yes _____

Activities that you may not been able to continue since your injury? _____

What have you tried for it?
Medications? □no □yes _____Did it help?_____
Splints? □no □yes _____ Did it help? _____
Injections? □no □yes _____ Did it help? _____
Ice or Heat? □no □yes _____ Did it help? _____

Have you seen any other providers for this? If yes, who? _____
□Emergency Room □Urgent Care Centers (Patient First, Rightime, etc)

What did they recommend? _____

Who recommend that you come see us today? _____