

**PATIENT INTAKE QUESTIONAIRRE**

**Physical Medicine**

Reason for visit. Please circle all that apply

Neck Pain

Shoulder Pain

Mid-Back Pain

Lower Back Pain

Hip Pain

Knee Pain

Ankle/Foot Pain

Describe the quality of your pain. Please circle all that apply

Stabbing

Burning

Dull

Aching

Numbness

Tingling

Radiating

When do you notice your pain the most? Please circle all that apply.

Morning

Afternoon

Evening

When did this Pain/Condition begin? (Be Specific please)

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Is there anything that makes this Pain/Condition Better?

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Is there anything that makes this Pain/Condition Worse?

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On a scale of 1-10 how would you rate your pain?

1 being very little pain/discomfort, 10 being maximum level of pain/discomfort.

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

Does this Pain/Condition Radiate/Refer anywhere else in the body?

(Shoulders, Elbow, Wrist, Hand, buttocks, behind the legs, feet?)

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How long have you been dealing with this pain?

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Are you currently being treated by any other professionals for any of your Pain/Condition? If so, by whom?

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Results? (Be Specific Please)

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Any previous injuries or accidents? If yes, please explain

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