

Kinetic Elements Physical Therapy

4250 8th Ave NW Suite 100 Seattle WA 98107

Subjective Intake Questionnaire

Today's date _____

Name: _____

Handedness

Right / Left

Who referred you?

- Physician Naturopath ARNP Chiropractor Yoga / Pilates / Fitness instructor
 Claims manager Attorney Other _____

Chief Condition / Current Complaint

Please describe the problem(s) that bring(s) you to PT: _____

Describe your symptoms (please check and indicate body region or part and describe)

- Numbness _____ Tingling _____ Aching _____ Sharp pain _____
 Dull pain _____ Burning _____ Dizziness/Lightheadedness
 Loss of range of motion _____ Weakness _____ Functional changes (eg. difficulty with stairs) _____
 Other _____

Are your symptoms related to an accident or specific injury? Y / N If yes, please describe

When did your symptoms begin? _____

Did your symptoms come on gradually? Y / N

Have you ever had this problem before? Y / N If yes, please describe

Did they previously get better? Y / N How? Y / N _____

What is the frequency of your symptoms?

- Constant Daily _____x/Day Weekly _____x/week

How are your symptoms progressing? Improving Worsening Staying the same

What makes your symptoms better? Heat Ice Exercise Rest Medication

Change position Walking Other _____

What makes your symptoms worse? Sitting Rising from sit to stand Standing

Walking Bending Squatting Stairs Kneeling Computer Lifting Other

Are you able to continue working? Yes, full duty Yes, Light duty No, as of _____

Are you able to continue your usual recreation? Yes Limited _____

Do you have periods of time when you are completely symptom free? Y / N

Do your symptoms awaken you at night? Y / N

If yes, how many times? _____/night What time? _____am/pm

Have you experienced any of the following with your current problem?

- Buckling
- Loss of balance
- Pain with cough/sneezing
- Lip numbness
- Locking
- Dislocating
- Bowel/bladder changes
- Unconsciousness
- Giving way
- Dizziness/blurred vision
- Numbness around groin

What treatment have you had for this complaint? (check all that apply)

- None
- Acupuncture
- Massage therapist
- Osteopath
- Rheumatologist
- Physical Therapy when _____ #visits _____
- Chiropractor
- OB/Gynecologist
- Pediatrician
- Psychiatrist
- Dentist
- Orthopedist
- Podiatrist
- Psychologist
- Physician
- Occupational therapist
- Neurologist/Neurosurgeon

Social/Health Information

Do you currently smoke? Y / N Amount _____
Did you smoke in the past? Y / N When quit? _____
Do you exercise regularly? Y / N
How many times per week? _____ How long per bout? _____
Please describe your exercise _____

Living Information

Does your home have: stairs railing uneven terrain other concerning obstacles _____
Do you use: cane walker wheelchair crutches other assistive devices _____

General Health Status

Please rate your average health: excellent good fair poor
Have you had any major changes in the recent year (i.e. new baby, death in family, job change, etc?)
Y / N please describe _____

Medical/Surgical History

- Arthritis
- Blood disorder
- High blood pressure
- Diabetes/High blood sugar
- Head injury
- Muscular dystrophy
- Allergies
- Cancer
- Repeated infections
- Other _____
- Broken bones/fractures
- Circulation/vascular disorder
- Lung problems
- Depression
- Parkinson's disease
- Thyroid conditions
- Kidney Problems
- Ulcer/stomach problems
- Osteopenia/Osteoporosis
- Heart problems
- Stroke
- Low blood sugar/hypoglycemia
- Multiple sclerosis
- Seizures/Epilepsy
- Developmental/growth problems
- Infectious disease(HIV, TB, HepC)
- Skin disorders

Within the past year, have you experienced any of the following symptoms?

- Chest pain
- Shortness of breath
- Loss of balance
- Joint pain/swelling
- Loss of appetite
- Weight loss/gain
- Hearing changes
- Other _____
- Heart palpitations
- Dizziness or blackouts
- Difficulty walking
- Pain at night
- Nausea/vomiting
- Urinary problems
- Vision changes
- unexplained cough
- Coordination problems
- Weakness in arms or legs
- Difficulty sleeping
- Bowel problems
- Headaches
- Numbness/tingling _____

Medications- check ALL Physician prescribed medications currently taking:

- | | | |
|--|---|--|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Tylenol/acetaminophen | <input type="checkbox"/> Anti-inflammatories |
| <input type="checkbox"/> Muscle relaxers | <input type="checkbox"/> Birth control pills | <input type="checkbox"/> Prescription pain relievers |
| <input type="checkbox"/> Antibiotics | <input type="checkbox"/> Stomach ulcer medication | <input type="checkbox"/> Hormone replacement therapy |
| <input type="checkbox"/> Diuretics | <input type="checkbox"/> Thyroid medications | <input type="checkbox"/> Heart medications _____ |
| <input type="checkbox"/> Antidepressants | <input type="checkbox"/> Seizure medications | <input type="checkbox"/> Asthma medications |
| <input type="checkbox"/> Insulin | <input type="checkbox"/> Decongestant/antihistamine | <input type="checkbox"/> Steroids |
| <input type="checkbox"/> Other _____ | | |

Medications- check ALL non-prescription medications currently taking:

- | | | |
|---|---|---|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Antacids (Tums, etc) | <input type="checkbox"/> Advil/Aleve/Motrin/Ibuprofen |
| <input type="checkbox"/> Decongestants | <input type="checkbox"/> Laxatives | <input type="checkbox"/> Tylenol/acetaminophen |
| <input type="checkbox"/> Herbal supplements _____ | | |
| <input type="checkbox"/> Other _____ | | |

Other Clinical Tests and Radiology

- | | | |
|---|---|---|
| <input type="checkbox"/> Angiogram | <input type="checkbox"/> Echocardiogram (EKG) | <input type="checkbox"/> Electroencephalogram (EEG) |
| <input type="checkbox"/> MRI _____ | <input type="checkbox"/> CT scan _____ | <input type="checkbox"/> Electromyogram (EMG) |
| <input type="checkbox"/> X-Ray _____ | <input type="checkbox"/> Myelogram | <input type="checkbox"/> Bone Scan |
| <input type="checkbox"/> Blood tests | <input type="checkbox"/> Spinal tap | <input type="checkbox"/> Stress tests (eg. Bike or treadmill) |
| <input type="checkbox"/> Pulmonary function tests | <input type="checkbox"/> Nerve conduction tests (NCV) | |
| <input type="checkbox"/> Other _____ | | |

Have you ever had surgery? Y / N If yes, please describe area and date:

Thank you!!