Divine Savior
HEALTHCARE

Name:

MR#:

DOB:

Date of Service

PLACE LABEL HERE
OR COMPLETE

REHAB SERVICES
New Patient Intake Questionnaire

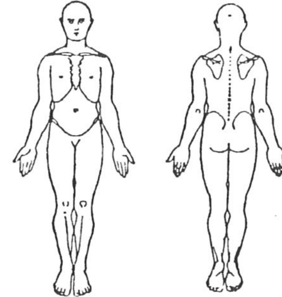
Name: ______________________ **DOB:** ______________ **Date:** ________________

Chief Complain/Problem: ____
When did it start? ________________ **Surgery Date (if applicable):** ________________
How did it occur? ☐ Uncertain or ____

Did injury happen at work? ☐ Yes ☐ No **Employer:** ________________________
Have you missed work due to current problem? ☐ No ☐ Yes ☐ **Work Restrictions?** ☐ No ☐ Yes ____________
Current Occupation: ____________________ ☐ Full Time ☐ Part Time ☐ As Needed ☐ Retired

Since Injury/Condition Started, is it..........? ☐ Getting Worse ☐ Getting Better ☐ Staying the same
Pain Level: (0 = no pain to 10 = Worst Pain): ___ / 10 (pain number now)
Pain Duration : ☐ Constant ☐ Comes/Goes
Pain Quality: ☐ Ache ☐ Sharp/Stabbing ☐ Other ______________

"X" location(s) of pain on diagram ➔



What activities are limited by your current problem?
☐ Sleeping ☐ Sitting ☐ Standing ☐ Walking ☐ Going Up/Down Stairs ☐ Reaching ☐ Lifting ☐ Pushing ☐ Carrying
☐ Dressing ☐ Bathing ☐ Household tasks ☐ Outdoor/yard tasks ☐ Childcare ☐ Driving ☐ Eating ☐ Work Tasks
☐ Sports/Recreation ☐ Other ____

Have you had any of the following services for this condition: ☐ Physical Ther. ☐ Occupational Ther. ☐ Chiropractic
☐ Athletic Trainer ☐ Speech ☐ Injections ☐ X-ray ☐ MRI ☐ Other ______________________

☐ **Do you exercise regularly?** ☐ No ☐ Yes (describe): ______________________________

Current Medications (☐ **List provided):** ____

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Medical History: (check all that apply)
☐ Cancer ☐ Hernia ☐ Arthritis ☐ Fibromyalgia ☐ Osteoporosis ☐ Ulcers ☐ Head Injury ☐ Epilepsy ☐ Diabetes
☐ Heart: ___ Heart Attack ___ High BP ___ Low BP ___ High Cholesterol ___ Pacemaker ___ Stroke/CVA ___ PVD
☐ Respiratory: ___ Asthma ___ Bronchitis ___ Emphysema ___ Smoker ___ Tuberculosis ___ Multiple Sclerosis ___ Kidney Stones ☐ Incontinence bladder or bowel ☐ Depression ☐ Hepatitis ☐ Recent unplanned weight loss ☐ Metal Implants
☐ Other Health Issues: ____
Allergies: ☐ Latex ☐ Bee stings ☐ Medications ☐ Other ______________________________
Previous Surgeries: ____
Women Only: ☐ Currently pregnant or may be pregnant

Religious/Cultural Practices affecting treatment: ☐ No ☐ Yes (describe): ____________________
How do you learn best? ☐ Verbal ☐ Demo ☐ Written ☐ Other: ______________________
Reading Preferences: ☐ English ☐ Other (describe): ______________________
Your goals for treatment? ☐ Decrease or no pain ☐ Improve motion ☐ Other: ______________

Patient Signature: ______________________________ **Date:** ______________

How did you hear about us? ___ **MD** ___ **Other:** ______________________________

DSRS-01 (2/12)