

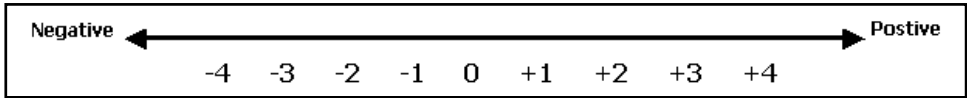
NRH Regional Rehab

PHYSICIAN INTAKE QUESTIONNAIRE

Revised 08/07/2008

Patient Name: _____
MR#: _____
DOB: _____

1. How many years of education have you completed? _____ years
2. What is your current marital status? (Check)
 Single Married Domestic Partner Separated Divorced Widowed
3. Do you currently smoke cigarettes? (Check)
 I never smoked Yes ___packs/day I quit in the last 6 months I quit more than 6 months ago
4. Do you currently drink alcohol? (Check)
 I never drink Rarely Occasionally/Socially Regularly Abuse Recovering Addiction
5. Do you currently use drugs other than Over-the-Counter not prescribed to you (street or prescription)? (Check)
 I never used Rarely Occasionally/Socially Regularly Abuse Recovering Addiction
6. Using the following scale, circle the number that reflects how you would rate your outlook on life most days?



7. Are you on or planning to apply to any of the following programs?

Program	Already on Program	If not on program, have you applied?	If not on program, do you plan to apply?
Social Security	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Disability	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Workers	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

8. Do you have an attorney representing you for this pain/injury? No Yes - Name _____
9. Usual Occupation _____ How long? _____
10. Employer _____ How long? _____
11. Is this episode of pain or injury work related? No Yes * **If Yes answer the following questions (12-16)**
12. What was your work status at the time of onset of this episode of pain/injury? (Check)
 Regular Full time Regular Part-time Permanent light duty Temporary light duty Disability or time loss Retired Not Working
13. What is your work status today? (Check)
 Regular Full time Regular Part-time Permanent light duty Temporary light duty Disability or time loss Retired Not Working
14. How physically demanding is your job? (Check) Sedentary Light Moderate Heavy Very Heavy Not Applicable
15. If you are currently employed but are not working, please indicate your level of agreement with each statement below.

	Strongly Agree	Agree	Disagree	Strongly Disagree
I am happy with my job	1	2	3	4
My family wants me to return to my job	1	2	3	4
My employer would be willing to make changes in my job to assist me returning to work (ie. reduce hours, decrease lifting demands, modify work station, etc.)	1	2	3	4
My employer took adequate steps to protect me from injury	1	2	3	4
I want to return to my job	1	2	3	4
I will return to work if successful treatment is offered	1	2	3	4
I will return to work if treatment is unsuccessful	1	2	3	4

16. Approximately how many hours per day did you spend performing the activities listed below while at work?

Activity /Number of Hours/Day:
 Driving _____ Sitting _____ Walking _____ Bending at the waist _____
 Light Lifting _____ Heavy Lifting _____ Standing _____