



ADAPT TRAINING | THERAPY INTAKE QUESTIONNAIRE

Name: _____

Diagnosis: _____

DAILY ROUTINE

Please explain your weekly activity in as much detail as possible. This will allow the therapists to get an accurate snapshot of your current schedule.

Morning Routine: _____

Regular daily/weekly activities (ie. training, workouts, range of motion, etc.) **& frequency of activities:**

Therapeutic daily/weekly activities (ie. PT/OT, massage, acupuncture, etc.) **& frequency of activities:**

Evening Routine: _____

Does your job/school require you to sit for extended periods of time? Average time spent sitting per day _____

How many hours per day (on average) are you active and moving around? _____

If you are wheelchair dependent, on average how many hours per day are you in your chair? _____

How many hours per day can you dedicate to your rehabilitation/recovery? _____



ACTIVITY

What was your activity level prior to your condition? _____

What activities are you interested in? _____

What is your current activity level (PT/OT, workouts, pool, etc.)? _____

What activities are limited by current condition? _____

If wheelchair dependent, do you have assistance available to help you with exercise activities? _____

GOALS

What are your short-term goals? _____

What do you think it will take to achieve these? _____

What are your long-term goals? _____

What do you think it will take to achieve these? _____

