ORTHOPEDIC & SPINE THERAPY **INTAKE FORM**

Date of Evaluation ____/____/____ Email________________________________Date of next MD visit ____/____/____

Name (first/middle initial/last) ____ Age _____ D.O.B. ____/____/____

Referring Physician ______________________________ Family Physician ___________________________________

Occupation/Job description (what do you actually do at work?) ____

Leisure Activities ______________________________ Living situation (House, Apt, Other)_______________________

How did you choose our facility? ❒ Physician ❒ Family ❒ Friend ❒ Location ❒ Advertisement ❒ Other ________

1. What problems or concerns would you like addressed? Explain: ____

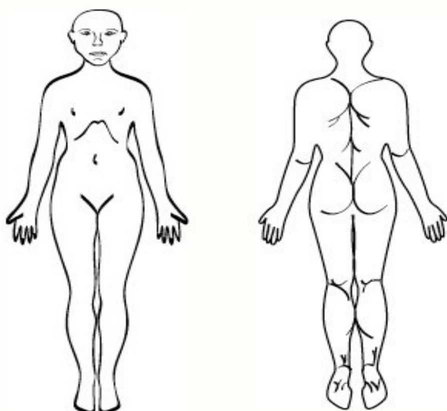
   ____

2. When did your problem develop? (exact date) ____/____/____

3. How did your problem begin? ____

4. Since your problem began, is it? ❒ Improving ❒Staying the same ❒ Worsening

5. Please note on the diagram where you're experiencing pain (using the appropriate letters):



T = Tingling
D = Dull
S = Sharp
N = Numbness
B = Burning
R = Radiating
A = Ache

6. Is your pain?

   ❒ Constant ❒ Intermittent

7. Express your pain on a scale of 0-10 (10 being extreme):

   ______ At present ______ At best ______ At worst

8. Are there any activities or positions that significantly worsen your symptoms?

   ❒ Sitting ❒ Standing ❒ Walking ❒ Lifting ❒ Lying down ❒ Ice ❒ Heat ❒ Coughing/Sneezing

   ❒ Bending ❒ Bowel or bladder movements ❒ Other ____

9. Are there any activities or positions that significantly improve your symptoms?

   ❒ Sitting ❒ Standing ❒ Walking ❒ Lifting ❒ Lying down ❒ Ice ❒ Heat ❒ Pain medications

   ❒ Bending ❒ Other ____

10. (PLOF) What could you do before your onset of pain? (daily activities, work, leisure) ________________________

____

(over)

11. Are you currently receiving the following treatment with another provider?

❒ Physical Therapy ❒ Chiropractic ❒ Massage ❒ Home Healthcare Services ❒ Skilled Nursing Facility Services

12. Have you had prior treatment(s) for this condition?

❒ Physical Therapy ❒ Chiropractic ❒ Injections ❒ Massage ❒ Surgery ❒ Acupuncture ❒ Other___________

13. Recent diagnostic tests? ❒ X-ray ❒ CT Scan ❒ MRI ❒ EMG ❒ Bone Scan ❒ Other _____________________

14. Please list all medications you are currently taking: ____

____

15. Have you ever had any of the following? (Please check all that apply.)

❒ Allergies
❒ Anxiety disorder
❒ Arthritis
❒ Bladder problems
❒ Blood clots
❒ Blood diseases
❒ Bowel problems
❒ Broken bones
❒ Cancer
❒ Chills
❒ Circulatory problems
❒ Depression
❒ Diabetes
❒ Dizziness
❒ Easy bleeding
❒ Emphysema
❒ Fatigue
❒ Fever
❒ Head injury
❒ Heart problems
❒ Headaches
❒ Hernia
❒ High blood pressure
❒ HIV/AIDS
❒ Implants
❒ Kidney problems
❒ Liver/Gallbladder
❒ Major trauma
❒ Metal implants
❒ Nausea
❒ Osteoporosis
❒ Pacemaker
❒ Pregnancy ❒ past ❒ present
❒ Rheumatoid
❒ Ringing in ears
❒ Seizures
❒ Skin problems
❒ Smoking ❒ past ❒ present
❒ Strokes
❒ Sweating
❒ Ulcers
❒ Vomiting
❒ Weakness
❒ Weight gain
❒ Weight loss

Please explain any checked items above and add others not listed: ____

____

16. Past surgical history: ____

____

17. What do you hope to accomplish in physical therapy?: ____

____

Patient Signature: ______________________________ Physical Therapist Signature: ______________________________

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