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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you choose our facility? Physician Family Friend Location Advertisement Other \_\_\_\_\_\_\_

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

Current work status Full time no restrictions Part time no restrictions Full time with restrictions

 Part time with restrictions Currently not working Medical Leave Maternity Leave Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Leisure Activities \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Living situation (House, Apt, Other)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you feel safe at home? Yes No Comment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How do you best learn? Listening Seeing Doing \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What problems or concerns would you like addressed? Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When did your problem develop? (exact date) \_\_\_\_/\_\_\_\_/\_\_\_\_

How did your problem begin? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

 Please circle: Are you R or L hand dominant?

 

T = Tingling

D = Dull

S = Sharp

N = Numbness

B = Burning

# R = Radiating

A = Ache

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

\_\_\_\_\_\_ At present \_\_\_\_\_\_ At best \_\_\_\_\_\_ At worst

Is your pain?

 Constant Intermittent

Are you right or left hand dominant?

 Right Left

List and score at least 3 activities that you are unable to perform, or have the most difficulty performing because of your chief complaint. On a 0-10 scale, the HIGHER the number the EASIER and the LOWER the number the more DIFFICULTY you have. (0= unable to perform activity; 10=fully able to perform activity)

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Score\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Score\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Score\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 Intercourse Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

 Sitting Standing Walking Lifting Lying down Ice Heat Pain medications

 Bending Bowel or bladder movements Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently receiving the following treatment with another provider?

 Physical Therapy Chiropractic Massage Home Healthcare Services Skilled Nursing Facility Services

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

 Physical Therapy Chiropractic Injections Massage Surgery Acupuncture Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Recent diagnostic tests? Bone Scan CT Scan EMG Urinalysis Urodynamics MRI X-ray Other\_\_\_\_\_\_\_\_\_\_\_\_

GENERAL HEALTH:

Please list all allergies: (*Please circle any that apply* ) seasonal / medications / latex /environmental / food / nickel

other: \_\_\_\_\_\_\_*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

Please list all medications you are currently taking: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Personal health rating: At the present time, would you say that your health is excellent very good fair poor

Please check all conditions below that apply to you.

|  |  |  |
| --- | --- | --- |
| HEART/ CIRCULATION* High blood pressure
* Pain/tightness in the chest
* Cold hands/feet
* Numbness hands/feet
* Anemia
* Blood clots
* Easy bleeding
* Heart attack
* Pacemaker
* Bypass surgery
* Heart murmur
* Other\_\_\_\_\_\_\_\_\_\_\_

LUNGS/BREATHING* Shortness of breath
* Current smoking
* History of smoking
* Asthma
* Emphysema/bronchitis
* COPD
* Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_

SKIN CONDITIONS* Eczema
* Contact dermatitis
* Lichens sclerosis
* Psoriasis
* Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 | BONES & JOINTS* Chronic fatigue syndrome
* Arthritis
* Rheumatoid arthritis
* Fibromyalgia
* Tailbone pain
* Osteoporosis
* Stress fracture
* Joint replacement
* Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_

OTHER MEDICAL CONDITIONS* Diabetes
* Cancer
* Melanoma
* Lupus
* Stroke
* Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_

OTHER MEDICAL CONDITIONS* Hearing loss
* Ringing in ears
* Vision/eye problems
* Dizziness
* Depression
* Anxiety
 | OTHER MEDICAL CONDITIONS (cont)* Headaches
* Hyperthyroid
* Anorexia/Bulimia
* Head injury
* Epilepsy/seizures
* Multiple sclerosis
* Irritable bowel syndrome
* Ulcers
* Hernia
* Kidney problems
* Hepatitis
* Alcohol/drug addiction
* Vomiting
* Unexplained weight change
* Sweating
* Chills
* Sexually transmitted disease
* Falls in last 6 months
* Metal implants
* HIV/ AIDS
* Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Past surgical history: (please include dates to the best of your ability)

|  |  |  |
| --- | --- | --- |
| joint replacement\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_spinal fusion\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_laminectomy/discectomy\_\_\_\_\_\_\_\_\_\_shoulder surgery\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_elbow/hand/wrist surgery\_\_\_\_\_\_\_\_hip surgery \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_knee surgery\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ankle/foot surgery\_\_\_\_\_\_\_\_\_\_\_\_\_\_hernia repair\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | cesarean section\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_hysterectomy\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_appendectomy (appendix removal) \_\_\_\_cholecystectomy (gall bladder removal) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_abdominal surgery \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_laparoscopy\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_bladder surgery\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_prostate surgery \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_hemorrhoid surgery\_\_\_\_\_\_\_\_\_\_\_\_\_ | gastric bypass \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ileostomy\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_colostomy\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_vasectomy\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_coccyx removal\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_abortion\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_D&C\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_pudendal nerve surgery\_\_\_\_\_\_\_\_\_\_other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

What do you hope to accomplish in physical therapy? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physical Therapist Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_