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: _____

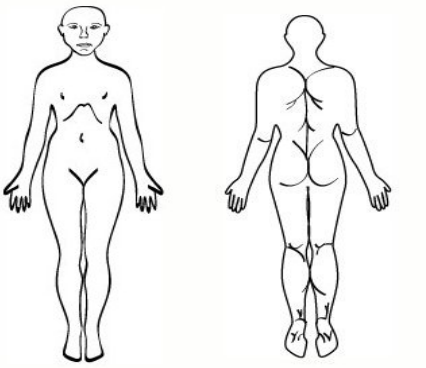
_____

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

Is your pain?

❒ Constant ❒ Intermittent

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

_____ At present _____ At best _____ At worst

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_____	❒cesarean section_____	❒gastric bypass _____
❒spinal fusion_____	❒hysterectomy_____	❒ileostomy_____
❒laminectomy/discectomy_____	❒appendectomy (appendix removal) ____	❒colostomy_____
❒shoulder surgery_____	❒cholecystectomy (gall bladder removal)	❒vasectomy_____
❒elbow/hand/wrist surgery_____	_____	❒coccyx removal_____
❒hip surgery _____	❒abdominal surgery _____	❒abortion_____
❒knee surgery_____	❒laparoscopy_____	❒D&C_____
❒ankle/foot surgery_____	❒bladder surgery_____	❒pudendal nerve surgery_____
❒hernia repair_____	❒prostate surgery _____	❒other_____
	❒hemorrhoid surgery_____	❒other_____

What do you hope to accomplish in physical therapy? _____
_____

Patient Signature: _____ Date: _____

Physical Therapist Signature: _____Date: _____

ORTHOPEDIC & SPINE THERAPY **PELVIC HEALTH INTAKE FORM**

URINARY FUNCTION *(Please check and circle all that apply)*:

❒ I estimate _____ (#)voids per day / _____ (#)voids per night,
❒ I leak urine when I(*please circle all that apply*): cough / sneeze / yell / jump / exercise / laugh / vomit / move from sitting to standing / other _____.
❒ I constantly leak urine.
❒ I sometimes am unable to make it to the toilet in time because the urge is so strong that I leak urine.
❒ Things that trigger my urge include (*please circle all that apply*): running water / key in door / cold / the bathroom / other_____.
❒ I have a (*choose one*) constant / intermittent stream of urine when I urinate.
❒ I have difficulty (*please circle all that apply*) starting / stopping my flow.
❒ I have to (*please circle all that apply*) strain / self-cath to completely empty my bladder.
❒ I do not feel like I completely empty my bladder when I urinate.
❒ I wear _____(#)pads per day for my urinary incontinence.
❒ I do daily pelvic floor exercises (kegels).

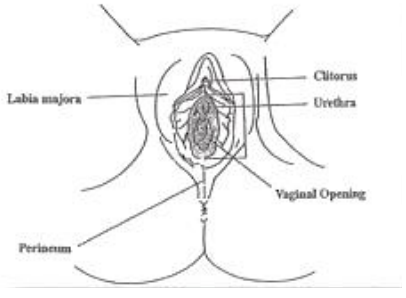
BOWEL FUNCTION *(Please check and circle all that apply)*:

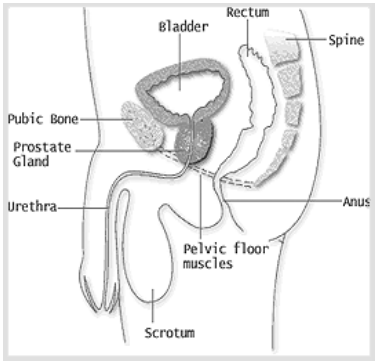
❒ I typically have _____(#)bowel movements per week / day (*circle one*).
❒ I leak (*please circle all that apply*) gas / stool.
❒ I wear _____ (#)pads per day for my fecal incontinence.
❒ I have irritable bowel syndrome. I typically have (*circle one*) constipation / diarrhea / mixed.
❒ To manage constipation I use: _____.
❒ I sometimes am unable to make it to the toilet in time because the urge is so strong that I leak feces.
❒ Things that trigger my urge include (*please circle all that apply*: eating / caffeine / running water / key in door / cold / the bathroom / other
_____.
❒ I have to splint my perineum with my hand when I have a bowel movement.
❒ I have to manually evacuate stool on occasionally.
❒I am experiencing rectal bleeding and/or blood in my stool.

NUTRITION/FLUID INTAKE /EXERCISE:

❒ I drink_____ (#) servings of water per day. (1 serving = 8 oz)
❒ I drink the following beverages (# servings) soda_____,diet soda_____,milk_____,regular coffee_____, tea_____, decaf coffee_____, juice_____,alcohol_____,other_____.
❒ I weigh _____ (#)pounds. I have a _____(#)pound weight loss/gain goal.
❒ I am currently dieting. The diet I am following is_____.
❒ I exercise _____(#)times per week. I typically walk (# times per week)_____/ run_____ / elliptical _____/cycle_____ / lift weights_____ / swim _____/ row_____ / do exercise classes _____/ do exercise videos_____ / yoga_____ / Pilates_____ / other _____.
❒I have/ had an eating disorder: ❒ anorexia ❒bulimia ❒other _____.

Please shade the areas of pain and write a number from 1 to 10 at the site(s) of pain. (10=most severe pain imaginable).





PAIN HISTORY *(Please check, circle or complete all that apply)*:

❒ I do not have problems with pain. *Please ignore the rest of this section.*

❒ I am sexually active at this time.

❒ I am sexually inactive due to pain.

❒ I am sexually inactive for other reasons.

MALES:

❒ My pain is worse during an erection.

❒ My pain is worse during ejaculation.

❒ My pain lingers after ejaculation for _____ days/hours/minutes.

❒ My pain is located: ❒ rectal area ❒penis ❒testicles ❒behind testicle ❒buttock ❒abdomen ❒My pain feels deep inside.

❒ I have pain after intercourse.

❒ When my bladder is full ❒Muscle/joint pain ❒Pain with urination ❒Backache ❒Migraine headache ❒Pain with sitting

FEMALES:

❒ My pain is worse during ovulation.

❒ My pain is worse just before my period.

❒ I have pain with intercourse.

❒ My pain feels close to the vaginal opening ❒My pain feels deep inside ❒Pain with orgasm ❒Other _____

❒ I have pain after intercourse.

❒ When my bladder is full ❒Muscle/joint pain ❒Burning vaginal pain after sex ❒Pain with urination ❒Backache ❒Migraine headache ❒Pain with sitting ❒Other_____

OBSTETRIC HISTORY *(Please check, circle or complete all that apply)*:

❒ I am not, nor have not ever been pregnant. *Please ignore the rest of the section and continue below*.*

❒ I am currently pregnant.

I am at ____weeks gestation, with the due date of _____.

❒Any concerns during this pregnancy? ❒No ❒Yes If yes, please specify:_____

❒Has your physician placed you on any restrictions? ❒No ❒Yes If yes, please specify: _____

❒ Number of pregnancies____ (including current if applicable)

❒ Number of vaginal deliveries____. Birth weights:_____

❒ Number of cesarean deliveries____ Birth weights:_____

❒ Number of episiotomies____

❒ Number of miscarriages____ Date(s):_____

❒ Complications during pregnancy, labor, delivery or post-partum?

❒Vacuum ❒Post-partum hemorrhaging ❒Forceps ❒Medication for bleeding ❒Post-partum depression

❒ Preeclampsia ❒Other _____

GYNECOLOGICAL HISTORY *(Please check, circle or complete all that apply)*:

❒ The first day of my last menstrual cycle was: _____.

❒ I have not started my menstrual cycle yet.

❒ I have started / completed (*Please circle one)* menopause.

❒If still menstruating, periods are: ❒Light ❒Moderate ❒Heavy ❒Bleed through protection

❒Any history of or currently have feelings of: ❒pelvic heaviness ❒fibroids ❒cysts ❒endometriosis

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Fill out this section ONLY of you have given birth in the last 12 weeks.

Answer the following 3 questions by placing a check mark next to your response:

IN THE LAST 7 DAYS:

I have blamed myself unnecessarily when things went wrong.	I have felt panicky or scared for no very good reason.	I have been anxious or worried for no good reason.
_____Yes, all the time	_____Yes, all the time	_____Yes, all the time
_____Yes, most of the time	_____Yes, most of the time	_____Yes, most of the time
_____No, not very often	_____No, not very often	_____No, not very often
_____No, not at all	_____No, not at all	_____No, not at all