ORTHOPEDIC & SPINE THERAPY

INTAKE FORM

Name _____ Date _____

DOB _____ Age _____

It is important for us to know how our patients hear about us. Who can we thank for your referral to OST?

☐ MD/NP ☐ Family ☐ Friend ☐ Newsletter ☐ Employer ☐ Social Media
☐ LinkedIn ☐ Advertisement ☐ Magazine ☐ Community Talk ☐ Website ☐ Other _____

Date of Evaluation __/__/__ **Email** _____ **Date of Next MD Visit** __/__/__

Referring Physician _____ **Family Physician** _____ **Occupation** _____

Job Description _____

Current Work Status:

☐ Full-time ☐ Full-time, with restrictions ☐ Not Working ☐ Maternity Leave
☐ Part-time ☐ Part-time, with restrctions ☐ Medical Leave ☐ Other _____

Leisure Activities _____ **Living Situation (House, Apt)** _____

Do you feel safe at home? ◯ Yes ◯ No ◯ Comment: _____

How do you best learn? ◯ Listening ◯ Seeing ◯ Doing ◯ Comment: _____

What specific issues do you want 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

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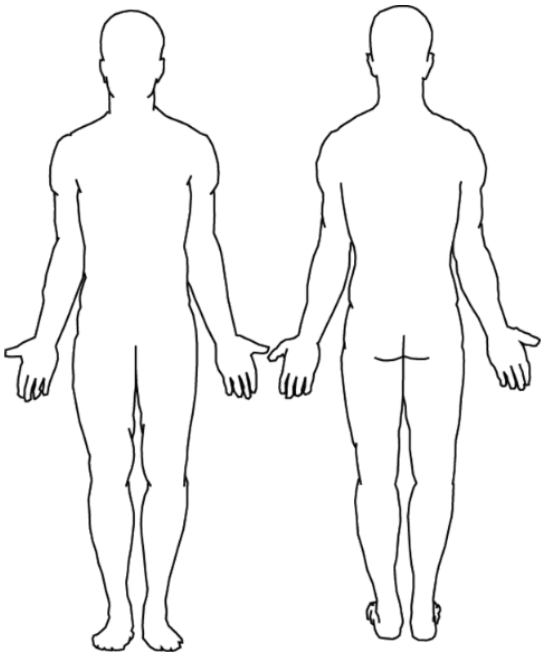
Please note on the diagram where you're experiencing pain, using the appropriate letters below:



T = Tingling
D = Dull
S = Sharp
N = Numbness
B = Burning

Are you right hand or left hand dominant? ○ Right ○ Left

Is your pain... ○ Constant ○ Intermittent

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

At present:

1 2 3 4 5 6 7 8 9 10

At best:

1 2 3 4 5 6 7 8 9 10

At worst:

1 2 3 4 5 6 7 8 9 10

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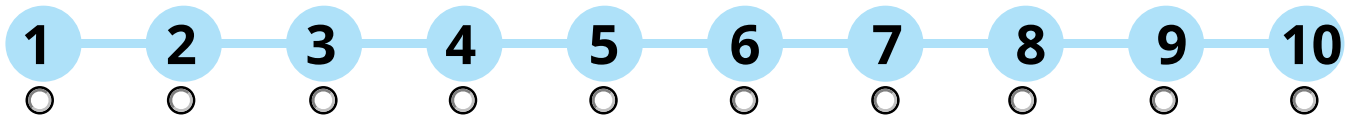
List and score at least 3 activities that you are unable to perform or have the most difficulty performing because of your chief complaint.

On a 0-10 scale, the **HIGHER** the number, the **EASIER**. The **LOWER** the number, the more **DIFFICULTY** you have. *0 = unable to perform activity ; 10 = fully able to perform activity*

_____



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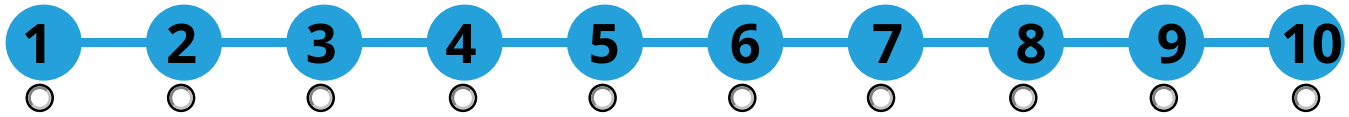

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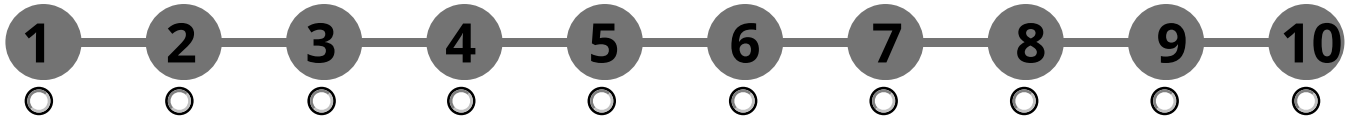

Are there any activities or positions that significantly *worsen* your symptoms?

☐Sitting ☐Walking ☐Lying down ☐Ice ☐Intercourse ☐Coughing/sneezing
☐Standing ☐Lifting ☐Bending ☐Heat ☐Other _____ ☐Bowel/ bladder movements

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

☐Sitting ☐Walking ☐Lying down ☐Ice ☐Intercourse ☐Pain medications
☐Standing ☐Lifting ☐Bending ☐Heat ☐Other _____ ☐Bowel/bladder movements

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

☐Physical therapy ☐Injections ☐Surgery ☐Other _____
☐Chiropractic ☐Massage ☐Acupuncture

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Are you currently receiving the following treatment with another provider?

- ☐ Physical therapy
- ☐ Home healthcare
- ☐ Nursing facility services
- ☐ Chiropractic
- ☐ Massage

Have you had any recent diagnostic tests?

- ☐ Bone scan
- ☐ EMG
- ☐ Urodynamics
- ☐ X-Ray
- ☐ CT scan
- ☐ Urinalysis
- ☐ MRI
- ☐ Other _____

Please list all allergies:

- ☐ Seasonal
- ☐ Medications
- ☐ Latex
- ☐ Other _____
- ☐ Food
- ☐ Nickel
- ☐ Environmental

Please list all medications you are currently taking:

_____

_____

At the present time, would you say that your health is... ◯ Excellent ◯ Very good ◯ Fair ◯ Poor

Past Surgical History *(please include dates to the best of your ability)*:

☐ joint replacement	_____	☐ cesarean section	_____	☐ gastric bypass	_____
☐ spinal fusion	_____	☐ hysterectomy	_____	☐ ileostomy	_____
☐ laminectomy/discectomy	_____	☐ appendix removal	_____	☐ colostomy	_____
☐ shoulder surgery	_____	☐ gall bladder removal	_____	☐ vasectomy	_____
☐ elbow/hand/wrist surgery	_____	☐ abdominal surgery	_____	☐ coccyx removal	_____
☐ hip surgery	_____	☐ laparoscopy	_____	☐ abortion	_____
☐ knee surgery	_____	☐ bladder surgery	_____	☐ D&C	_____
☐ ankle/foot surgery	_____	☐ prostate surgery	_____	☐ pudendal nerve surgery	_____
☐ hernia repair	_____	☐ hemorrhoid surgery	_____	☐ other	_____
		☐ implanted devices	_____	☐ other	_____

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Please check *all conditions* below that apply to you:

HEART & CIRCULATION

- ☐ High blood pressure
- ☐ Pain/tightness in the chest
- ☐ Cold hands/feet
- ☐ Numbness in hands/feet
- ☐ Amemia
- ☐ Blood clots
- ☐ Easy bleeding
- ☐ Heart attack
- ☐ Pacemaker
- ☐ Bypass surgery
- ☐ Heart murmur
- ☐ Other_____

LUNGS & BREATHING

- ☐ Shortness of breath
- ☐ Currently 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
- ☐ Scoliosis
- ☐ Other_____

OTHER MEDICAL CONDITIONS

- ☐ Diabetes
- ☐ Cancer
- ☐ Melanoma
- ☐ Lupus
- ☐ Stroke
- ☐ Hearing loss
- ☐ Ringing in ears
- ☐ Vision/eye problems
- ☐ Dizziness
- ☐ Depression
- ☐ Anxiety
- ☐ Prolapse
- ☐ Incontinence
- ☐ Headaches
- ☐ Hyperthyroid
- ☐ Anorexia/bulimia

MEDICAL CONDITIONS CONT.

- ☐ 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 the last 6 months
- ☐ Metal implants
- ☐ Breast implants
- ☐ HIV/AIDS
- ☐ Other_____
  _____
  _____
  _____

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Please explain any checked items in the chart and add others not listed.

_____

_____

What do you hope to accomplish in physical therapy?

_____

_____

Patient signature _____ **Date:** ___/___/___

Physical Therapist Signature_____ **Date:** ___/___/___