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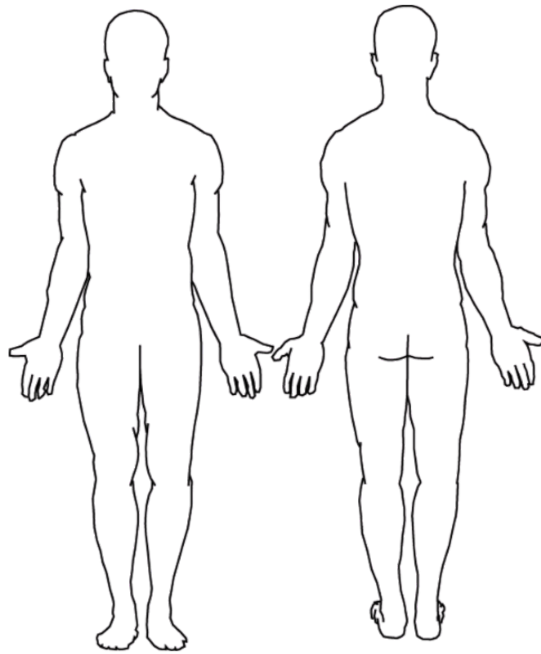
**Please note on the diagram where you're experiencing pain, using the appropriate letters below:**



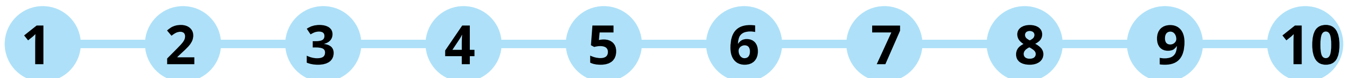
**T** = Tingling
**D** = Dull
**S** = Sharp
**N** = Numbness
**B** = Burning

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

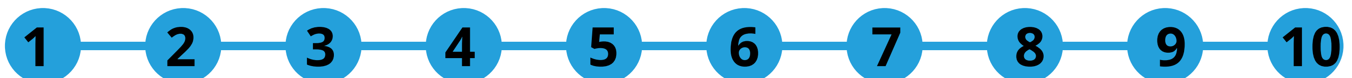
**Is your pain...** Constant Intermittent

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

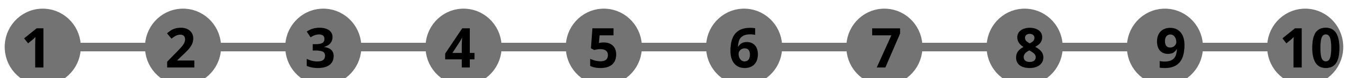
*At present:*




*At best:*




*At worst:*



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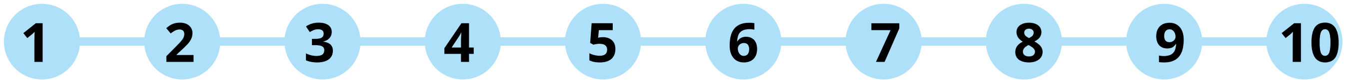
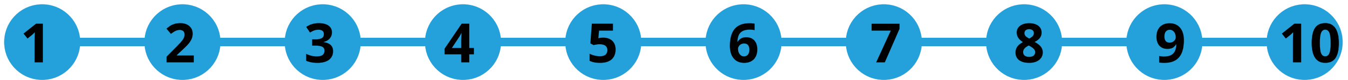
**List and score at least 3 activities that you are unable to perform or have the most difficulty performing because of your chief complaint.**

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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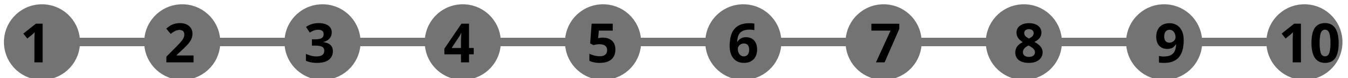


**Are there any activities or positions that significantly *worsen* your symptoms?**

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

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

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

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

Physical therapy
Chiropractic
Injections
Massage
Surgery
Acupuncture
Other __________

# ORTHOPEDIC & SPINE THERAPY

## INTAKE FORM

**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 | _______ |

# ORTHOPEDIC & SPINE THERAPY

## INTAKE FORM

**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_______________

_____________________

_____________________

_____________________

# ORTHOPEDIC & SPINE THERAPY

## INTAKE FORM

**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:** ___/___/___