ORTHOPEDIC SPINE THERAPY

INTAKE FORM

Name _____ Date of Evaluation _____

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 _____

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 __/__/__

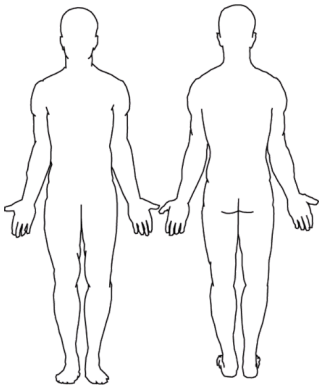
How did your problem begin? _____

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

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

Is your pain... ◯ Constant ◯ Intermittent

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

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

At present:

0 1 2 3 4 5 6 7 8 9 10

At best:

0 1 2 3 4 5 6 7 8 9 10

At worst:

0 1 2 3 4 5 6 7 8 9 10

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

_____

0 1 2 3 4 5 6 7 8 9 10

_____

0 1 2 3 4 5 6 7 8 9 10

_____

0 1 2 3 4 5 6 7 8 9 10

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

Are you currently receiving the following treatment with another provider?

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

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

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

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	_____

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
- ☐ Anemia
- ☐ 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_____
  _____
  _____
  _____

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:** ___/___/___