



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 restrictions 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 ____/____/____

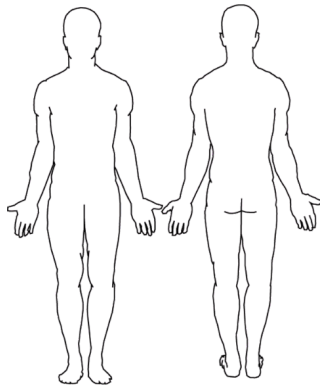
How did your problem begin? _____

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

PERSONAL GOALS

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 | 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

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: ___/___/___