ORTHOPEDIC SPINE THERAPY

Patient 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 *(optional, provide name)* _____ ☐ Newsletter ☐ Employer ☐ Social Media
☐ Linkedin ☐ Advertisement ☐ Magazine ☐Community Talk ☐ Website ☐Other _____

Email _____ **Next MD Visit** ___/___/___ **Referring MD**_____

Family MD _____**Occupation**_____ **Job Description**_____

Work Status: ☐ Full-time ☐ Full-time, with restrictions ☐ Part-time ☐ Part-time, with restrictions
☐ Not Working/Retired ☐ Maternity Leave ☐ Medical Leave ☐ Other _____
Does your injury prevent you from working? ☐ Yes ☐ No If yes, do you desire to return to work? ☐ Yes ☐ No
Living Situation: ☐ House ☐ Apartment **Do you feel safe at home?** ☐ Yes ☐ No ☐ _____

Leisure Activities _____
How do you learn best? ☐ Listening ☐ Seeing ☐ Doing ☐ Comment _____

What specific issues do you want addressed? _____

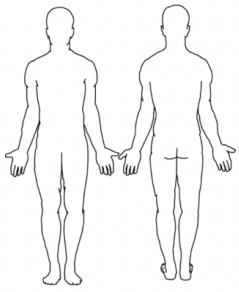
When did your problem develop? Exact Date ___/____/_____

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:** ☐ Consistent ☐ 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

Rate your pain: 1 - 10 (10 being extreme): At present: _____ **At best:** _____ **At worst:** _____

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

Activity: _____ **Score:** _____

Activity: _____ **Score:** _____

Activity: _____ **Score:** _____

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 ☐ Coughing/sneezing ☐ 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 ☐ Chiropractic ☐ Massage ☐ Acupuncture
☐ Other _____

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 ☐ Food ☐ Nickel ☐ Environmental ☐ Other _____

Please list all medications you are currently taking (or attach list) :

_____

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 _____
☐ Spinal fusion _____
☐ Laminectomy/discectomy_____
☐ Shoulder surgery_____
☐ Elbow/hand/wrist surgery _____
☐ Hip surgery _____
☐ Knee surgery _____
☐ Ankle/foot surgery _____
☐ Hernia repair _____
☐ Cesarean section_____
☐ Hysterectomy_____
☐ Appendix removal _____
☐ Gallbladder removal_____
☐ Abdominal surgery_____
☐ Laparoscopy_____
☐ Bladder surgery_____
☐ Prostate surgery_____
☐ Hemorrhoid surgery_____
☐ Implanted devices_____
☐ Gastric bypass_____
☐ Ileostomy_____
☐ Colostomy_____
☐ Vascetomy_____
☐ Coccyx removal_____
☐ Abortion
☐ D&C_____
☐ Prostate surgery_____
☐ Pudendal nerve surgery_____
☐ Other_____

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

HEART & CIRCULATION	BONES & JOINTS	LUNGS & BREATHING
☐ 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 _____	☐ Chronic fatigue syndrome ☐ Arthritis ☐ Rheumatoid arthritis ☐ Fibromyalgia ☐ Tailbone pain ☐ Osteoporosis ☐ Easy bleeding ☐ Stress fracture ☐ Joint replacement ☐ Bypass surgery ☐ Scoliosis ☐ Other _____	☐ Shortness of breath ☐ Currently Smoking ☐ History of smoking ☐ Asthma ☐ Emphysema/bronchitis ☐ COPD ☐ Other_____

SKIN CONDITIONS	OTHER MEDICAL CONDITIONS	OTHER MEDICAL CONDITIONS
☐ Eczema ☐ Contact Dermatitis ☐ Lichens Sclerosis ☐ Psoriasis ☐ Other_____	☐ Diabetes ☐ Cancer ☐ Melanoma ☐ Lupus ☐ Stroke ☐ Hearing Loss ☐ Ringing in ears ☐ Vision/eye problems ☐ Dizziness ☐ Depression ☐ Anxiety ☐ Prolapse ☐ Incontinence ☐ Headaches ☐ Hyperthyroid ☐ Hypothyroid	☐ 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 ___/_____/_____ PT Initials _____