ORTHOPEDIC SPINE THERAPY

ORTHOPEDIC & SPINE THERAPY INTAKE FORM

Date of Evaluation ____ /____ /____ Email _____ Date of next MD visit ____ /____ /____

Name (First/MI/Last) _____ Age _____ D.O.B ____ /____ /____

Referring Physician _____ Family Physician _____

How did you choose our facility? ☐Physician ☐Family ☐Friend ☐Location ☐Advertisement ☐Other _____

Occupation/Job Description (What do you do at work?) _____

Current Work Status ☐Full-time, no restrictions ☐Part-time, no restrictions ☐Full-time, with restrictions

☐Part-time, with restrictions ☐Currently not working ☐Medical Leave ☐Maternity Leave ☐Other _____

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

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

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

What problems or concerns would you like addressed? Explain: _____

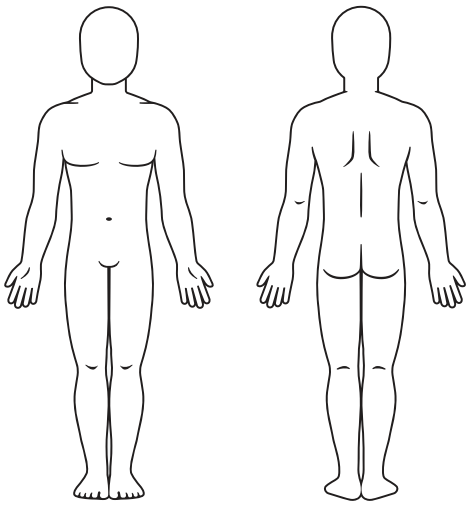
_____

When did your problem develop? (Exact date) ____ /____ /____

How did your problem begin? _____

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

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

Express your pain on a scale of 0-10 (10 being extreme):
_____ At present _____ At best _____ At worst

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 and the LOWER the number, the more DIFFICULTY you have. (0 = unable to perform activity; 10 = fully able to perform activity)

1. _____ Score_____

2. _____ Score_____

3. _____ Score_____

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

☐Sitting ☐Standing ☐Walking ☐Lifting ☐Lying down ☐Ice ☐Heat ☐Coughing/Sneezing ☐Bending

☐Bowel or bladder movements ☐Intercourse ☐Other _____

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

☐Sitting ☐Standing ☐Walking ☐Lifting ☐Lying down ☐Ice ☐Heat ☐Pain medications ☐Bending

☐Bowel or bladder movements ☐Other _____

Are you currently receiving the following treatment with another provider?

☐Physical Therapy ☐Chiropractic ☐Massage ☐Home Healthcare Services ☐Skilling Nursing Facility Services

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

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

Have you had any recent diagnostic tests? ☐Bone Scan ☐CT Scan ☐EMG ☐Urinalysis ☐Urodynamics ☐MRI

☐X-Ray ☐Other _____

General Health

Please list all allergies: ☐Seasonal ☐Medications ☐Latex ☐Environmental ☐Food ☐Nickel

☐Other _____

Please list all medications you are currently taking: _____

_____

Personal health rating: At the present time, would you say that your health is ○excellent ○very good ○fair ○poor

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
- ☐Other _____

OTHER MEDIATION CONDITIONS
- ☐Diabetes
- ☐Cancer
- ☐Melanoma
- ☐Lupus
- ☐Stroke

- ☐Hearing loss
- ☐Ringing in ears
- ☐Vision/eye problems
- ☐Dizziness
- ☐Depression
- ☐Anxiety
- ☐
- ☐
- ☐

OTHER MEDIATION CONDITIONS (cont.)
- ☐Headaches
- ☐Hyperthyroid
- ☐Anorexia/Bulimia
- ☐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 last 6 months
- ☐Metal implants
- ☐HIV/AIDS
- ☐Other _____

_____

_____

_____

_____

_____

Please explain any checked items above and add others not listed:

_____

_____

_____

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

☐joint replacement _____	☐cesarean section _____	☐gastric bypass _____
☐spinal fusion _____	☐hysterectomy _____	☐ileostomy _____
☐laminectomy/disectomy _____	☐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 _____

What do you hope to accomplish in physical therapy? _____

_____

Patient Signature: _____ Date: _____

Physical Therapist Signature: _____ Date: _____