BAUDENDISTEL PHYSICAL THERAPY

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Patient Intake Form

DATE:

Please fill this out to the best of your ability. Your therapist will review it with you.

Patient information		
Name:	DOB:	Gender:
Height:	Weight:	Hand dominance: Right | Left
Doctor:		
Diagnosis:		

Date of Injury (approximate): _____ **Next doctor appointment:** _____

Onset: Was the onset of pain or other symptoms: ❑ slow or ❑ rapid?

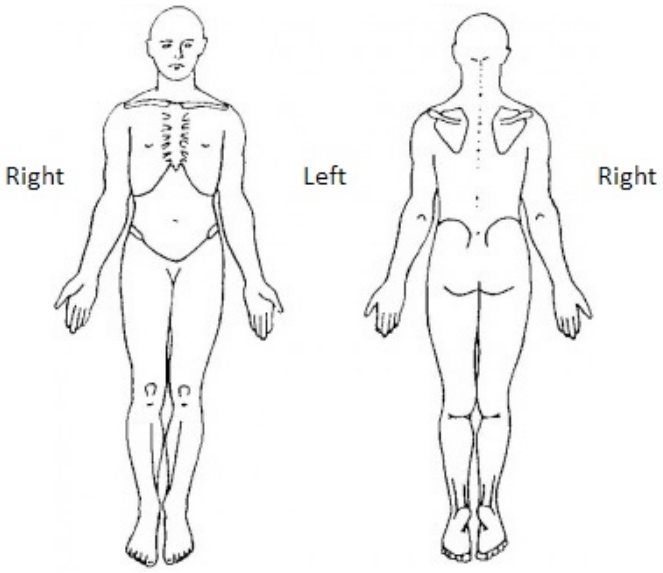
How did the injury occur? (Please describe incident. Example: "I was lifting a 40 lb. box from the ground, rotated my trunk to the right, and felt immediate pain in my low back and neck".

_____

_____

_____

Location: On the body diagrams, draw where you have pain or other symptoms.



Progression (check one)**:**

❑ I am getting better.
❑ I am staying the same.
❑ I am getting worse.

Improvement: If you are improving, what percent are you already better in all of your painful areas?

_____

_____

_____

Aggravating activities (check any activities that make your pain or symptoms worse. Please estimate how long you can do each aggravating activity before having to stop due to too much pain)

❑ Standing	_____	❑ Lift / carry	_____	❑ lying on side (knees bent)	_____	❑ Sex	_____
❑ Walking	_____	❑ Lying flat on back	_____	❑ Cough / sneeze	_____	❑ Push	_____
❑ sitting	_____	❑ Lying flat on stomach	_____	❑ Overhead activities	_____	❑ Pull	_____
❑ Sit to stand	_____	❑ bending	_____	❑ Other:			

Are there any activities which cause increased symptoms at home? (For example: vacuuming, carrying groceries, yardwork)

Are there any recreation activities you are no longer able to participate in? (example: walking, sports, bicycling, etc.)

Easing activities (check any that decrease your pain or symptoms)

❑ Ice ❑ Heat ❑ Rest ❑ Medication ❑ Change in position ❑ Other:

24 hour behavior

Number of times waking at night: _____ Reason: _____

Are your symptoms better or worse in the following:

Morning	Afternoon	Evening	Night
❑ Better	❑ Better	❑ Better	❑ Better
❑ No change	❑ No change	❑ No change	❑ No change
❑ Worse	❑ Worse	❑ Worse	❑ Worse

Work status

Current / most recent occupation: _____ Last date worked: _____

Currently working:

❑ Full-time ❑ Part-time ❑ Light duty ❑ Not working ❑ Retired ❑ Other: _____

Medical history

Have you had a previous injury to the same area you are being treated for now? (*When? How did the injury occur?*)

Have you ever been treated for this injury before? (*When? What type of treatment? Did it help?*)

Any possible health complications we should be aware of?

❑ Heart	❑ Lungs	❑ Diabetes	❑ High blood pressure
❑ Rheumatoid arthritis	❑ Osteoarthritis	❑ Cancer	❑ Pregnancy
❑ Other:			

Imaging (list dates and results)

- ❑ X-ray _____
- ❑ MRI _____
- ❑ Bone scan _____
- ❑ C-T scan _____
- ❑ Blood study _____
- ❑ Other _____

Medications (list name if you remember it)

- ❑ Pain killers / opioids (i.e. norco) _____
- ❑ Muscle relaxers (i.e. flexeril) _____
- ❑ Anti-inflammatory / NSAIDS (i.e. advil) _____
- ❑ Steroids (i.e. cortizone) _____
- ❑ Other _____