THERAPY SERVICES INTAKE

NAME:_____ GENDER: M / F DOB:_____

DATE OF INJURY / SURGERY:_____ OCCUPATION / HOBBIES:_____

What is your reason for coming to therapy today?_____

_____

When did your problem begin?_____

_____

How did your problem start?_____

_____

Have you had any diagnostic testing for this condition? (Check all that apply)

☐ MRI ☐ CT ☐ X-RAY ☐ BONE SCAN ☐ MBSS

Do you have the results? ☐ Yes ☐No

Have you had any previous treatment for this condition?

☐ Medication ☐ Physical Therapy ☐ Occupational Therapy

☐ Speech Therapy ☐ Injection(s) ☐ Chiropractic

☐ Surgery ☐ Home Health ☐ Other:_____

Disability level prior to injury / onset of symptoms:

☐ No limitations ☐ Mildly limited ☐ Moderately limited ☐ Severely limited

Current disability level:

☐ No limitations ☐ Mildly limited ☐ Moderately limited ☐ Severely limited

What are your goals as a result of attending therapy?

☐ **Decrease Pain** ☐ **Less difficulty with work activities** ☐ **Sleep longer**

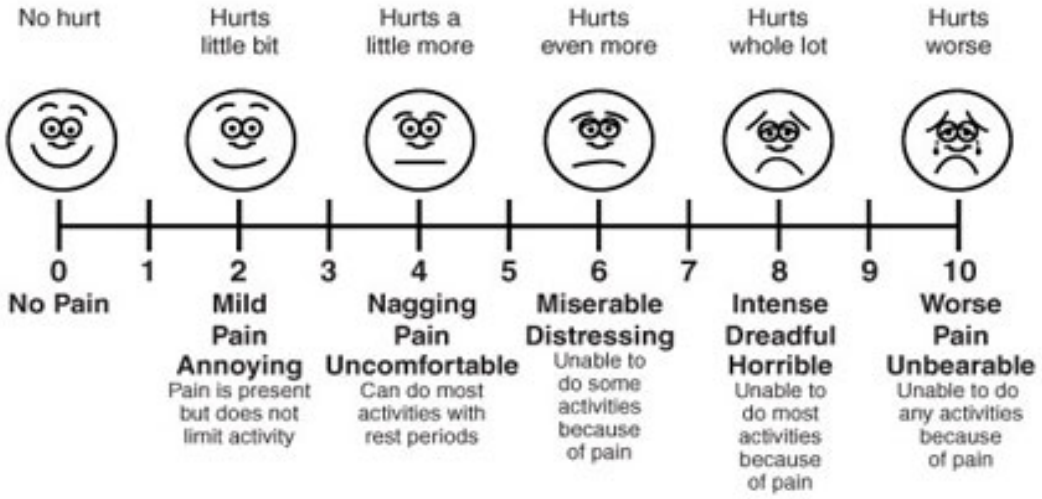
☐ **Improve movement** ☐ **Improve strength** ☐ **Stand Longer** ☐ **Sit Longer**

☐ **Return to recreation activities / sports** ☐ **Less difficulty with home activities**

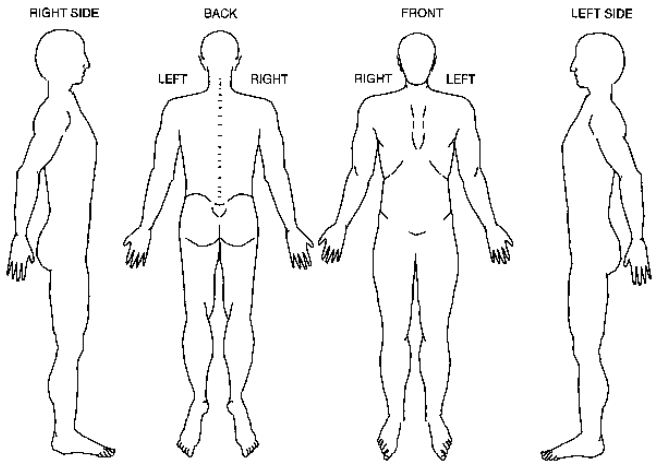
☐ **Less difficulty with self care** ☐ **Increase communication skills**

☐ **Eat without choking** ☐ **Other:**_____

Rate your pain on a scale of 0-10 (0 being no pain and 10 being the worst) _____/10 Today



Please mark the location of your pain on the picture below:



MEDICAL HISTORY: (Please check all that apply)

☐ Allergies ☐ Anemia ☐ Arthritis ☐ Cancer ☐ Cardiac Disease ☐ COPD

☐ Depression ☐ Anxiety ☐ Diabetes ☐ Dizziness ☐ Fractures

☐ Hypertension ☐ Incontinence ☐ Osteoarthritis ☐ Osteoporosis ☐ Stroke

☐ Parkinson's ☐ Rheumatoid Arthritis ☐ Seizures ☐ Fibromyalgia

☐ Autoimmune Disease ☐ Pacemaker ☐ Internal Stimulator

☐ Asthma ☐ Bronchitis ☐ Emphysema

☐ Other:_____

Have you RECENTLY noted any of the following:

☐ Nausea / Vomiting ☐ Dizziness / Lightheadedness ☐ Bowel or bladder changes

☐ Difficulty maintaining balance / Falls ☐ Weight loss/gain ☐ Shortness of breath

☐ Headaches ☐ Changes in appetite ☐Fever/chills/sweats ☐ Night pain

☐ Weakness / Fatigue ☐ Difficulty swallowing ☐ Slurred speech

☐ Trouble understanding / keeping on task ☐ Trouble getting thoughts out

☐ Other:_____

If you are a woman, is there any chance you may be pregnant? ☐ Yes ☐ No

If yes, what is your estimated due date?_____

Are you allergic to adhesive / tape or latex? If yes, please list:_____

Please list any medications, vitamins, or supplements that you are currently taking:

_____

_____

_____

Please list any surgeries that you have had with the approximate date or year of the procedure:

_____

_____

Patient Signature:_____ **Date:**_____

Therapist Signature:_____ **Date:**_____


NTMC
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