ADVANCED ORTHOPAEDICS AND SPORTS MEDICINE-THERAPY SERVICES
INITIAL INTAKE FORM

Please complete ALL information Date: _____

Name: _____ Sex: ☐ M ☐ F DOB: _____

Referring Doctor: _____ Primary Physician: _____

CHIEF COMPLAINT:

Explain why you are here to see the physical therapist: ☐ MVA ☐ Work Injury ☐ Other: _____

_____

When did your symptoms start: _____ ☐ Suddenly ☐ Gradually ☐ Don't know

What caused your current problem: _____

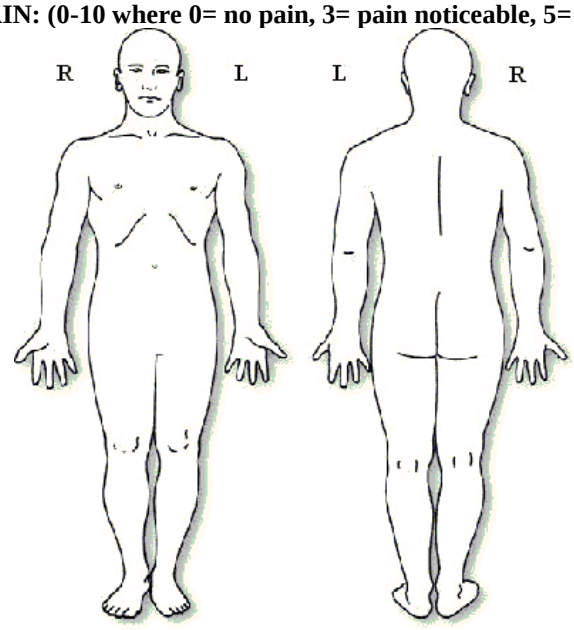
How does this problem affect you? ☐ Interferes with recreational activities ☐ Interferes with dressing/grooming

☐ Wakes you up at night ☐ Interferes with Yard work. ☐ Interferes with cooking/cleaning/dependent care

☐ Interferes with work activities: (Occupation: _____)

Currently working ☐ Yes ☐ No. Last date worked:_____

PAIN: (0-10 where 0= no pain, 3= pain noticeable, 5= pain needs modification of activity, 7= crying, 10=ER)



Indicate on body diagram any areas of pain including radiating pain, numbness, tingling
(**xxxxx**: Numbness /////: Tingling)

Worst pain felt for current condition:

0 1 2 3 4 5 6 7 8 9 10

Least pain felt for current condition:

0 1 2 3 4 5 6 7 8 9 10

Current level of pain:

0 1 2 3 4 5 6 7 8 9 10

Nature of pain:

☐ Intermittent ☐ Sharp ☐ Constant ☐ Dull

☐ Shooting ☐ Aching ☐ _____

Increasing factors: _____

Decreasing factors: _____

Are your symptoms getting: ☐ Better ☐ Worse ☐ No change

TESTS/TREATMENTS/RESTRICTIONS/MEDICATIONS:

Have you had any of the following for this problem: ☐ Physical Therapy ☐ MD/DO

☐ Chiropractor ☐ Injections/Blocks ☐ Surgery ☐ _____

Have you had any of the following tests for this problem: ☐ X-Ray ☐ MRI ☐ CT Scan ☐ EMG/Nerve Test

☐ _____ Results (if known) _____

List current medication: _____

Has physician placed you under any restrictions: ☐ No ☐ Yes, _____

Any assistive device you must use at this time: ☐ Cane ☐ Crutches ☐ Walker ☐ Wheelchair ☐ Brace

What are your goals for therapy? _____

PAST MEDICAL AND SOCIAL HISTORY:

Do you smoke : ☐ Yes ☐ No If you are female, are you pregnant: ☐ Yes ☐ No

Do you exercise at least three days a week: ☐ Yes ☐ No Height: _____ Weight: _____ lbs

Do you currently have of have had in the past problems with (check all that apply) ☐ No problems listed below

☐ Asthma	☐ Arrythmia	☐ Allergies	☐ Balance disorders
☐ Bleeding tendency	☐ Cancer	☐ Diabetes	☐ Dizziness
☐ Fracture	☐ Heart Attack	☐ Hernia	☐ High Blood Pressure
☐ Hepatitis	☐ Headaches	☐ Incontinence	☐ Infectious diseases
☐ Metal implant	☐ Osteoarthritis	☐ Osteoporosis	☐ Pacemaker
☐ Psychological	☐ Rheumatoid Arthritis	☐ Respiratory (Bronchitis, Emphysema)	
☐ Stroke	☐ Seizures/epilepsy	☐ Surgeries _____	

Do you take blood thinners? ☐ Yes ☐ No

REVIEW OF SYSTEMS: Currently I am experiencing (Please check all that apply): ☐ No problems listed below

☐ Change in apetite	☐ Weight gain/loss	☐ Fever/chills	☐ Chest Pain
☐ Dizziness	☐ Depression	☐ Shortness of breath	☐ Numbness/ Tingling
☐ Headaches	☐ Poor balance/ Falls	☐ Nausea/Vomiting	☐ Difficulty swallowing
☐ Increased night pain	☐ Weakness	☐ Change in bowel and bladder symptoms	

Do you have any barriers to learning? ☐ No ☐ Yes, list _____

Are there any reasons that may limit your ability to participate in therapy ☐ No ☐ Yes, list (work, transportation etc) _____

I certify that, to the best of my knowledge, all information listed above is true. I further certify that I have not misstated or intentionally omitted any information related to my health or past medical history. It is my responsibility to inform the clinic of any change in my medical status. I understand that my diagnosis and treatment plan will be discussed during my appointment and I have the right to question and/or refuse any treatments offered. I acknowledge that no guarantees have been made as to the results of outcomes or examinations.

_____ _____

Signature of patient (or patients representative) Date