

INTAKE INFORMATION

Date:

Patient Name:

Current Age:

Please complete the following information in detail. This will assist us in designing the most effective and efficient individualized program for you. Every item is significant and important. Thank you for your effort. Please print neatly.

Who recommended you to this office? _____

Official Diagnosis or Main Problem: _____

Reason for visit (if different from above) _____

IMPORTANT:

To the patient: Please list below the main complaints/challenges you have in order of their importance:

1. _____

2. _____

3. _____

4. _____

5. _____

Which Doctor referred you to our clinic? (List Below)

Give us their name and address:

Please report all current areas of pain and the usual range of pain (0 no pain, 10 excruciating/debilitating pain).

RANGES OF PAIN: (For Example √ Head 4-7)

- | | | |
|---|--|--|
| <input type="checkbox"/> Head _____ | <input type="checkbox"/> Right Lower Arm _____ | <input type="checkbox"/> Right Front Thigh _____ |
| <input type="checkbox"/> Face _____ | <input type="checkbox"/> Left Lower Arm _____ | <input type="checkbox"/> Left Front Thigh _____ |
| <input type="checkbox"/> Jaw _____ | <input type="checkbox"/> Right Wrist _____ | <input type="checkbox"/> Right Back Thigh _____ |
| <input type="checkbox"/> Front of Neck _____ | <input type="checkbox"/> Left Wrist _____ | <input type="checkbox"/> Left Back Thigh _____ |
| <input type="checkbox"/> Back of Neck _____ | <input type="checkbox"/> Right Fingers _____ | <input type="checkbox"/> Right Knee _____ |
| <input type="checkbox"/> Right Side of Neck _____ | <input type="checkbox"/> Left Fingers _____ | <input type="checkbox"/> Left Knee _____ |
| <input type="checkbox"/> Left Side of Neck _____ | <input type="checkbox"/> Upper Back _____ | <input type="checkbox"/> Right Shin _____ |
| <input type="checkbox"/> Right Shoulder _____ | <input type="checkbox"/> Chest/Rib Cage _____ | <input type="checkbox"/> Left Shin _____ |
| <input type="checkbox"/> Left Shoulder _____ | <input type="checkbox"/> Abdomen _____ | <input type="checkbox"/> Right Foot _____ |
| <input type="checkbox"/> Right Upper Arm _____ | <input type="checkbox"/> Low Back _____ | <input type="checkbox"/> Left Foot _____ |
| <input type="checkbox"/> Left Upper Arm _____ | <input type="checkbox"/> Buttocks _____ | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Right Elbow _____ | <input type="checkbox"/> Right Hip _____ | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Left Elbow _____ | <input type="checkbox"/> Left Hip _____ | <input type="checkbox"/> _____ |

Please indicate what makes your pain worse:

- __Lying Down __Sitting __Standing __Walking __Driving __Running __Working
__Time of Day __Too Much Activity __Bending __Reaching __Lifting __Squatting
__Kneeling __Too Little Activity __Other (Specify): _____
-

What makes your pain decrease? (Explain):

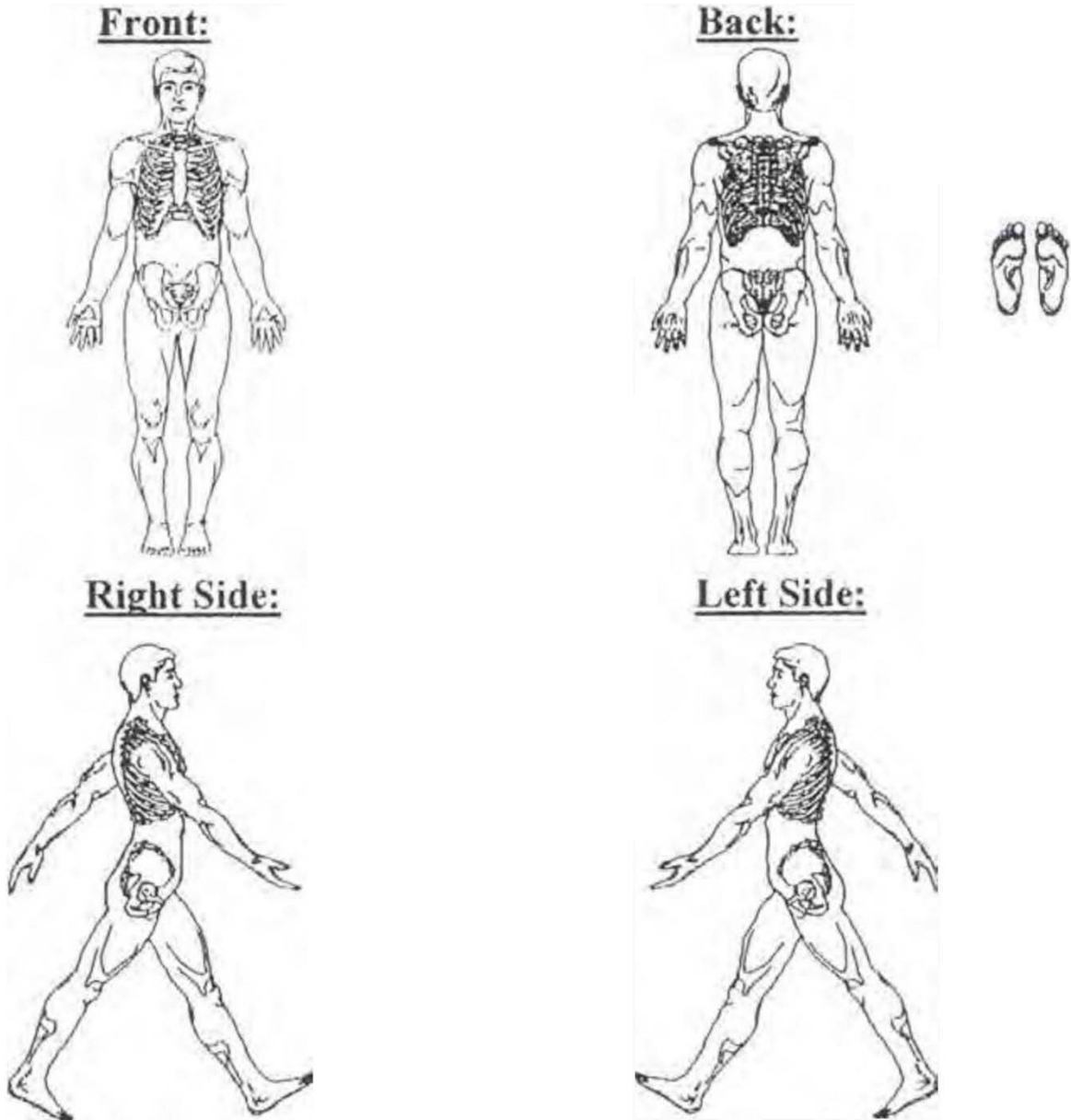
- __Lying Down __Sitting __Standing __Walking __Driving __Running __Working
__Time of Day __Too Much Activity __Bending __Reaching __Lifting __Squatting
__Kneeling __Too Little Activity __Other (Specify): _____
-

When did your pain begin? (Weeks, Months, Years ago)?

At Birth? _____ Date: _____

Was your onset of pain sudden? Gradual? Explain (if necessary):

Pain Diagram: Please shade in all areas of pain. Be as thorough and specific as possible.

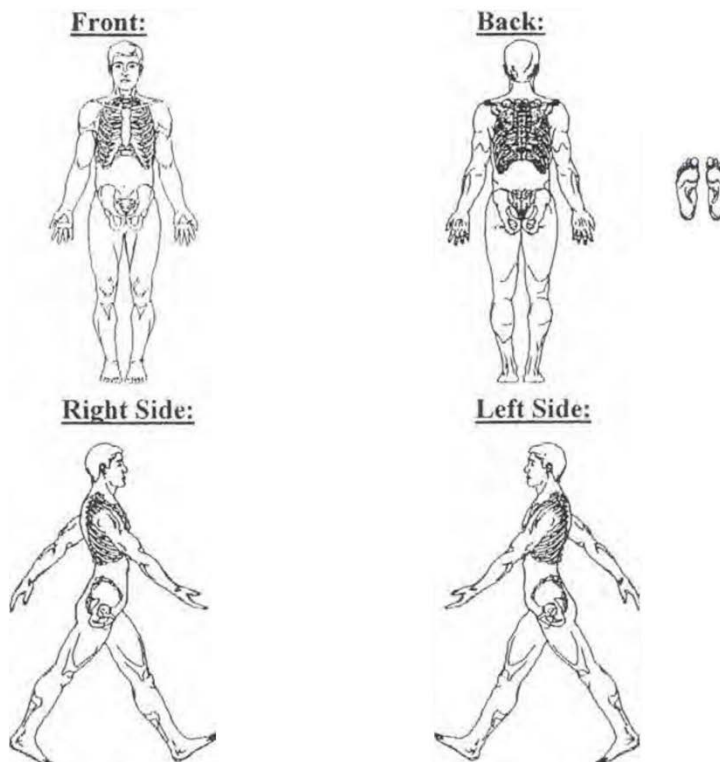


Therapist: Please put this page in the patient's chart.

Paresthesia: Please check the following areas of "funny feeling" (tingling, burning, pins and needles, etc.)

- | | | |
|---|--|--|
| <input type="checkbox"/> Head | <input type="checkbox"/> Right Lower Arm | <input type="checkbox"/> Right Front Thigh |
| <input type="checkbox"/> Face | <input type="checkbox"/> Left Lower Arm | <input type="checkbox"/> Left Front Thigh |
| <input type="checkbox"/> Jaw | <input type="checkbox"/> Right Wrist | <input type="checkbox"/> Right Back Thigh |
| <input type="checkbox"/> Front of Neck | <input type="checkbox"/> Left Wrist | <input type="checkbox"/> Left Back Thigh |
| <input type="checkbox"/> Back of Neck | <input type="checkbox"/> Right Fingers | <input type="checkbox"/> Right Knee |
| <input type="checkbox"/> Right Side of Neck | <input type="checkbox"/> Left Fingers | <input type="checkbox"/> Left Knee |
| <input type="checkbox"/> Left Side of Neck | <input type="checkbox"/> Upper Back | <input type="checkbox"/> Right Shin |
| <input type="checkbox"/> Right Shoulder | <input type="checkbox"/> Chest/Rib Cage | <input type="checkbox"/> Left Shin |
| <input type="checkbox"/> Left Shoulder | <input type="checkbox"/> Abdomen | <input type="checkbox"/> Right Foot |
| <input type="checkbox"/> Right Upper Arm | <input type="checkbox"/> Low Back | <input type="checkbox"/> Left Foot |
| <input type="checkbox"/> Left Upper Arm | <input type="checkbox"/> Buttocks | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Right Elbow | <input type="checkbox"/> Right Hip | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Left Elbow | <input type="checkbox"/> Left Hip | <input type="checkbox"/> _____ |

Paresthesia Diagram: Please shade in all areas of "funny feeling" (tingling, burning, pins and needles, etc.)



Therapist: Please place this page in the patient's chart.

Patient Name: _____

Please tell us about your symptoms by checking the appropriate areas:

	<u>Frequency</u>			<u>Severity</u>		
	Occasional	Often	Constant	Mild	Moderate	Severe
Dizziness, Light-headed						
Pass out easily (faint)						
Decreased concentration/ attention						
Short term memory loss						
Slurred speech						
Balance or coordination problems						
Headaches						
Nausea						
Indigestion						
Difficulty swallowing						
Ears: ringing, stuffy, painful						
Vision: blurring, burning, aching, pressure, change, double						
Drooping eyelid or any changes in your pupils						
Allergies						
Sinus problems						
Nagging cough, hoarseness						
Chest Pain						
Cold hands						
Cold feet						
Bowel problems						
Unusual bleeding or discharge						
Sexual function problems						
Change in any wart or mole						
Sore that does not heal						
Thickening in your breast/elsewhere						
Snore						
Pain wakes you from a sound sleep						
Night sweats						

Function: Activities of daily living are compromised as follows:

Bed Activities:

<input type="checkbox"/> Lying on stomach is	<input type="checkbox"/> Painful	<input type="checkbox"/> Difficult	<input type="checkbox"/> Not Possible
<input type="checkbox"/> Lying on back is	<input type="checkbox"/> Painful	<input type="checkbox"/> Difficult	<input type="checkbox"/> Not Possible
<input type="checkbox"/> Lying on right side is	<input type="checkbox"/> Painful	<input type="checkbox"/> Difficult	<input type="checkbox"/> Not Possible
<input type="checkbox"/> Lying on left side is	<input type="checkbox"/> Painful	<input type="checkbox"/> Difficult	<input type="checkbox"/> Not Possible
<input type="checkbox"/> Rolling over in bed is	<input type="checkbox"/> Painful	<input type="checkbox"/> Difficult	<input type="checkbox"/> Not Possible

Transfer Activities:

<input type="checkbox"/> Lying to sit is	<input type="checkbox"/> Painful	<input type="checkbox"/> Difficult	<input type="checkbox"/> Not Possible
<input type="checkbox"/> Sit to lying is	<input type="checkbox"/> Painful	<input type="checkbox"/> Difficult	<input type="checkbox"/> Not Possible
<input type="checkbox"/> Sit to stand is	<input type="checkbox"/> Painful	<input type="checkbox"/> Difficult	<input type="checkbox"/> Not Possible

Standing is:

<input type="checkbox"/> Painful	<input type="checkbox"/> Difficult	<input type="checkbox"/> Not Possible
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Present standing tolerance: _____ min/hours

Sitting is:

<input type="checkbox"/> Painful	<input type="checkbox"/> Difficult	<input type="checkbox"/> Not Possible
----------------------------------	------------------------------------	---------------------------------------

Present standing tolerance: _____ min/hours

Driving is:

<input type="checkbox"/> Painful	<input type="checkbox"/> Difficult	<input type="checkbox"/> Not Possible
----------------------------------	------------------------------------	---------------------------------------

Present standing tolerance: _____ min/hours

Sitting in a car is:

<input type="checkbox"/> Painful	<input type="checkbox"/> Difficult	<input type="checkbox"/> Not Possible
----------------------------------	------------------------------------	---------------------------------------

Present standing tolerance: _____ min/hours

Walking is:

<input type="checkbox"/> Painful	<input type="checkbox"/> Difficult	<input type="checkbox"/> Not Possible
----------------------------------	------------------------------------	---------------------------------------

Present standing tolerance: _____ min/hours

Running is:

<input type="checkbox"/> Painful	<input type="checkbox"/> Difficult	<input type="checkbox"/> Not Possible
----------------------------------	------------------------------------	---------------------------------------

Present standing tolerance: _____ min/hours

Work is:

<input type="checkbox"/> Painful	<input type="checkbox"/> Difficult	<input type="checkbox"/> Not Possible
----------------------------------	------------------------------------	---------------------------------------

Present standing tolerance: _____ min/hours

Stairs are:

<input type="checkbox"/> Painful	<input type="checkbox"/> Difficult	<input type="checkbox"/> Not Possible
----------------------------------	------------------------------------	---------------------------------------

Present standing tolerance: _____ min/hours

Bending and lifting activities are:

<input type="checkbox"/> Painful	<input type="checkbox"/> Difficult	<input type="checkbox"/> Not Possible
----------------------------------	------------------------------------	---------------------------------------

Reaching activities (with arms) are:

<input type="checkbox"/> Painful	<input type="checkbox"/> Difficult	<input type="checkbox"/> Not Possible
----------------------------------	------------------------------------	---------------------------------------

Sport and leisure activities are:

<input type="checkbox"/> Compromised	<input type="checkbox"/> Not Possible
--------------------------------------	---------------------------------------

All activities/ADL's are performed despite

<input type="checkbox"/> pain	<input type="checkbox"/> fatigue	<input type="checkbox"/> lack of energy
<input type="checkbox"/> headaches		

Other: _____ painful lack of energy

How many hours do you sleep at night? _____

How many hours per day (in 24 hours) do you spend in bed? _____

How would you consider your present level of activity? ___Poor ___ Fair ___Good

Please list your present hobbies: _____

Work/Occupation:

Please state what you do for a living: _____

Please indicate the hours you spend at work per week: _____

Or

If you are currently not working, how long have you not worked? _____

Are you not working for reasons other than your pain/problem? Yes No

If so, what reason? _____

Are you a full-time homemaker? Yes No

	Before pain/disability	After pain/disability
Hours per week spent working at a paying job		
Hours per week spent doing household chores		
Hours per week spent doing a volunteer job		

Are you presently receiving compensation (disability insurance)? Yes No

If not, are you considering, or have you applied for compensation of any kind? _____

If you anticipate returning to work, when do you hope to do so? _____

Please describe how your present living situation is different from the way it was before you experienced pain/disability problems: _____

Current Assistive Devices:

- Cane Yes No
- Walker Yes No
- Manual Wheelchair Yes No
- Motorized Wheelchair Yes No
- Corrective Lenses/Glasses Yes No
- Heating Aids Yes No
- Dentures Yes No
- Prosthetics Yes No
- Shunts Yes No
- Pacemaker Yes No
- Insulin Pump Yes No
- Baclofen Pump Yes No
- Other: Yes No

Present Home Environment:

- Stairs, no railing Yes No
 - Stairs, railing Yes No
 - Ramps Yes No
 - Elevator Uneven Terrain Yes No
 - Bathroom modifications Yes No
 - Any other obstacles: _____
-

Current and Past Medical History:

- Alcoholism _____
- Allergies _____
- Alzheimer's Disease _____
- Arthritis _____
- Asthma _____
- Attention Deficit Disorder (ADD) _____
- Attention Deficit Hyperactivity Disorder _____
- Autoimmune Disease _____
- Back Pain _____
- Bronchitis _____
- Cancer/What Type _____
- Carpal Tunnel Syndrome _____
- Cerebral Palsy _____
- Cholesterol, Elevated _____
- Chronic Fatigue Syndrome _____
- Circulatory Problems _____
- Colitis _____

- Dental Problems _____
- Depression _____
- Diverticular Disease _____
- Drug Addiction _____
- Eating Disorder _____
- Epilepsy _____
- Environmental Sensitivities _____
- Eyes, Ears, Nose, Throat Problems _____
- Facial Palsy _____
- Fibromyalgia _____
- Food Intolerance _____
- Genetic Disorder _____
- Glaucoma _____
- Gout _____
- Headaches/Frequency: _____ Duration: _____ Intensity Range 0-10: _____
- Heart Disease _____
- High Blood Pressure _____
- Infection, Chronic (Type) _____
- Inflammatory Bowel Disease _____
- Irritable Bowel Syndrome _____
- Kidney or Bladder Disease _____
- Learning Disabilities _____
- Liver or Gallbladder Disease (Stones) _____
- Lymphedema _____
- Lymphatic Problems _____
- Mental Illness _____
- Mental Retardation _____
- Migraine Headaches/Frequency: _____ Duration: _____ Intensity Range 0-10: _____
- Mononucleosis _____
- Multiple Sclerosis _____
- Musculoskeletal Problems _____
- Obesity _____
- Osteoporosis
- Parkinson's
- Phobias
- Pneumonia
- Quadriplegia
- Respiratory Problems
- Rheumatoid Arthritis
- Seasonal Affective Disorder
- Sexually Transmitted Disease

- Sinus Problems _____
- Skin Problems _____
- Spina Bifida _____
- Stroke _____
- Thyroid Trouble _____
- Traumatic Brain Injury (TBI) _____
- Tuberculosis _____
- Ulcer _____
- Urinary Tract Infection _____
- Varicose Veins _____
- Other _____
- Other _____
- Other _____

Medical (Men):

- Benign Prostatic Hypertrophy _____
- Decreased Sex Drive _____
- Infertility _____
- Prostate Cancer _____
- Sexually Transmitted Disease _____
- Other _____
- Other _____

Medical (Women):

- Breast Cancer _____
- Breast Surgery/Reduction/Implants _____
- Decreased Sex Drive _____
- Endometriosis _____
- Fibrocystic Breasts _____
- Fibroids/Ovarian Cysts _____
- Infertility _____
- Menstrual irregularities _____
- What was the date of onset of last menses? _____
- Pelvic Inflammatory Disease _____
- PMS _____
- Sexually Transmitted Disease: _____
- Vagina Infections _____
- Other _____
- Other _____

List all trauma and when it occurred (All trauma, accidents injuries are important, not just recent ones.): _____

List any operations you have undergone and dates (approximately): _____

List any hospitalizations and dates (approximately): _____

What was your last vaccination/inoculation? _____

Did you become ill? Yes No

When have you traveled out of the country? _____

Did this require inoculation? Yes No

Did you become ill? Yes No

Are you losing weight without trying? Yes No

Are you coughing up blood or noticing it in your stool or urine? Yes No

Have you lost consciousness or had double vision recently? Yes No

Family Health History:

- Alcoholism _____
- Alzheimer's Disease _____
- Arthritis _____
- Asthma _____
- Cancer _____
- Depression _____
- Diabetes _____
- Drug Addiction _____
- Eating Disorder _____
- Genetic Disorder _____
- Glaucoma _____
- Heart Disease _____
- High Blood Pressure _____
- Infertility _____
- Learning Disabilities _____
- Mental Illness _____
- Mental Retardation _____
- Migraine Headaches _____
- Neurological Disorders (Parkinson's, Paralysis) _____
- Obesity _____
- Osteoporosis _____
- Rheumatoid Arthritis _____
- Stroke _____
- Other _____
- Other _____

Health Habits:

- Tobacco: Cigarettes #/day ____ Cigars #/day ____ Pipe ____ Chewing ____
- Alcohol: Wine or beer #glasses/day or week ____ Liquor# ounces/day or week ____
- Caffeine: Coffee: #6 oz cups/day ____ Tea: #6 oz cups/day ____
- Soda w/caffeine: # cans/day ____ Diet Sodas #cans/day ____
- Other: _____

Exercise: (Check all that apply)

- 5-7 days per week
- 3-4 days per week
- 1-2 days per week
- Infrequent
- Never
- 45 minutes or more duration per workout
- 30-45 minutes duration per workout
- Less than 30 minutes
- Swim
- Walk
- Run, Jog, Jump Rope
- Box
- Yoga
- Other:
- Other:

Nutrition and Diet:

- Vegetarian
- Vegan
- High Protein
- Salt Restriction
- Low Fat Diet
- Starch/Carbohydrate Restriction
- The Zone Diet
- Atkins Diet
- Other: _____
- Other: _____

Specific Food Restrictions:

- Dairy Eggs Soy Corn All Gluten Wheat Sugar
- Other: _____

Circle the level of stress you are experiencing on a scale of 1-10 (1 being the lowest):

1 2 3 4 5 6 7 8 9 10

Identify the major causes of stress (e.g., changes in job, work, residence or finances, legal problems): _____

List any prescribed, over the counter medications and/or supplements you are taking.

Name of those presently taking	Dosage	For how long?	List any Medications/Supplements you have Taken during the past 5 Years:

- Attach a piece of paper if needed.

Are you seeing any doctors or health care professionals now or for any reason?

Note: These practitioners will not be contacted without your permission. Do you want us to send our evaluation note to these practitioners? Yes No

Practitioner's Name	Type of Practitioner	Phone Number or Address
_____	_____	_____
_____	_____	_____
_____	_____	_____

While you are a patient here at **Total Health PT** a goal list will help us recognize what you would like to accomplish. Your therapist will evaluate you with your input in mind. **"Patient Centered Goals"** will serve as the basis for treatment. Goals will be revised as needed.

Please fill in the following so the therapist can consider your desires/goals.

The following examples are provided to assist you to answer.

I know I will be better when I can:

Example 1: Walk independently for 15 minutes with no pain

Example 2: Work using just a splint for a half day with occasional pain

Example 3: Sit with the help of only one person for 30 seconds.

Example 4: Play 18 holes of golf without pain in my back.

Please fill in the chart below, answering "I know I will be better when I can":

1. _____
2. _____
3. _____
4. _____
5. _____