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)

□ Head	_____	□ Right Lower Arm	_____	□ Right Front Thigh	_____
□ Face	_____	□ Left Lower Arm	_____	□ Left Front Thigh	_____
□ Jaw	_____	□ Right Wrist	_____	□ Right Back Thigh	_____
□ Front of Neck	_____	□ Left Wrist	_____	□ Left Back Thigh	_____
□ Back of Neck	_____	□ Right Fingers	_____	□ Right Knee	_____
□ Right Side of Neck	_____	□ Left Fingers	_____	□ Left Knee	_____
□ Left Side of Neck	_____	□ Upper Back	_____	□ Right Shin	_____
□ Right Shoulder	_____	□ Chest/Rib Cage	_____	□ Left Shin	_____
□ Left Shoulder	_____	□ Abdomen	_____	□ Right Foot	_____
□ Right Upper Arm	_____	□ Low Back	_____	□ Left Foot	_____
□ Left Upper Arm	_____	□ Buttocks	_____	□ _____	_____
□ Right Elbow	_____	□ Right Hip	_____	□ _____	_____
□ Left Elbow	_____	□ Left Hip	_____	□ _____	_____

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):

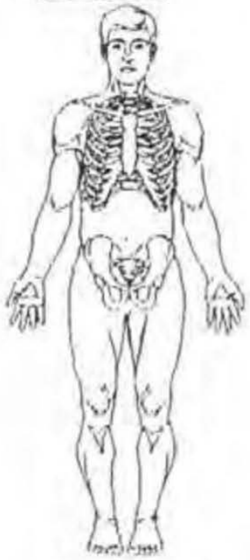
_____

_____

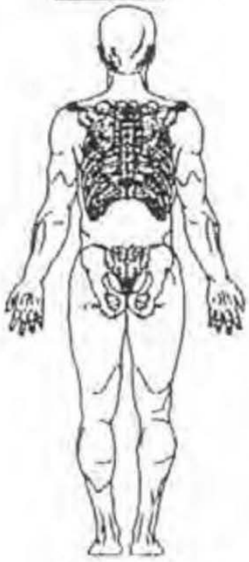
_____

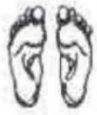
Pain Diagram: Please shade in all areas of pain. Be as thorough and specific as possible.

Front:



Back:





Right Side:

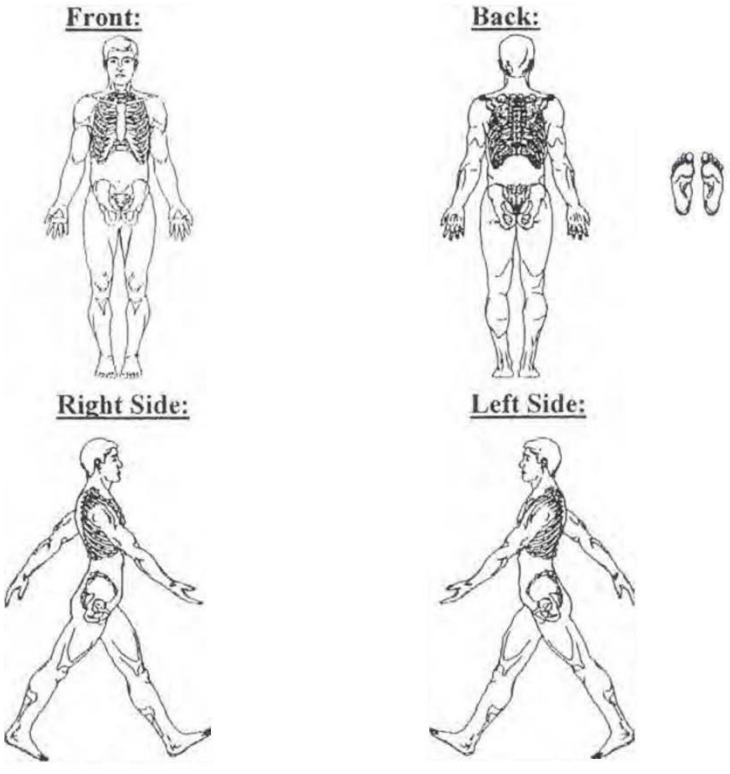
Left Side:

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.)

☐ Head	☐ Right Lower Arm	☐ Right Front Thigh
☐ Face	☐ Left Lower Arm	☐ Left Front Thigh
☐ Jaw	☐ Right Wrist	☐ Right Back Thigh
☐ Front of Neck	☐ Left Wrist	☐ Left Back Thigh
☐ Back of Neck	☐ Right Fingers	☐ Right Knee
☐ Right Side of Neck	☐ Left Fingers	☐ Left Knee
☐ Left Side of Neck	☐ Upper Back	☐ Right Shin
☐ Right Shoulder	☐ Chest/Rib Cage	☐ Left Shin
☐ Left Shoulder	☐ Abdomen	☐ Right Foot
☐ Right Upper Arm	☐ Low Back	☐ Left Foot
☐ Left Upper Arm	☐ Buttocks	☐ _____
☐ Right Elbow	☐ Right Hip	☐ _____
☐ Left Elbow	☐ Left Hip	☐ _____

<u>Paresthesia Diagram:</u> 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:

	Frequency			**Severity**		
	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:	□ Lying on stomach is	□ Painful	□ Difficult	□ Not Possible
	□ Lying on back is	□ Painful	□ Difficult	□ Not Possible
	□ Lying on right side is	□ Painful	□ Difficult	□ Not Possible
	□ Lying on left side is	□ Painful	□ Difficult	□ Not Possible
	□ Rolling over in bed is	□ Painful	□ Difficult	□ Not Possible
Transfer Activities:	□ Lying to sit is	□ Painful	□ Difficult	□ Not Possible
	□ Sit to lying is	□ Painful	□ Difficult	□ Not Possible
	□ Sit to stand is	□ Painful	□ Difficult	□ Not Possible

Standing is: □ Painful □ Difficult □ Not Possible
Present standing tolerance: _____ min/hours

Sitting is: □ Painful □ Difficult □ Not Possible
Present sitting tolerance: _____ min/hours

Driving is: □ Painful □ Difficult □ Not Possible
Present driving tolerance: _____ min/hours

Sitting in a car is: □ Painful □ Difficult □ Not Possible
Present car sitting tolerance: _____ min/hours

Walking is: □ Painful □ Difficult □ Not Possible
Present walking tolerance: _____ min/hours

Running is: □ Painful □ Difficult □ Not Possible
Present running tolerance: _____ min/hours

Work is: □ Painful □ Difficult □ Not Possible
Present work tolerance: _____ min/hours

Stairs are: □ Painful □ Difficult □ Not Possible
Present stair tolerance: _____ min/hours

Bending and lifting activites are: □ Painful □ Difficult □ Not Possible

Reaching activities (with arms) are: □ Painful □ Difficult □ Not Possible

Sport and leisure activities are: □ Compromised □ Not Possible

All activites/ADL's are performed despite □ pain □ fatigue □ lack of energy □ 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
Hearing 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 _____
□ Intellectual Disability_____
□ 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 _____
□ Intellectual Disability_____
□ 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. _____