



17131

PT/OT Patient Intake Form
(version 1.5)

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Last name

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First name

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PLEASE COMPLETELY FILL IN THE ONE CIRCLE THAT BEST DESCRIBES YOUR ANSWER. (Example: ●)

1. Why are you here today? If there are many reasons, please choose only the most important or most severe one.

- | | | | | |
|--|--------------------------------|-----------------------------|--|-------------------------------------|
| <input type="radio"/> Neck | <input type="radio"/> Shoulder | <input type="radio"/> Hip | <input type="radio"/> Stroke rehabilitation | Other (also indicate region) |
| <input type="radio"/> Upper/
mid-back | <input type="radio"/> Elbow | <input type="radio"/> Knee | <input type="radio"/> Spinal cord rehabilitation | <input type="radio"/> Post-surgical |
| <input type="radio"/> Lower back | <input type="radio"/> Wrist | <input type="radio"/> Ankle | <input type="radio"/> Neurologic rehabilitation | <input type="radio"/> Fracture |
| | <input type="radio"/> Hand | <input type="radio"/> Foot | <input type="radio"/> Balance/coordination | <input type="radio"/> Other |

2. When did this problem first begin?

- Less than 1 month ago 1-3 months ago 4-6 months ago 7-12 months ago More than 1 year ago

Has this problem...

No Yes

3. ... resulted from a work injury (i.e. workers' compensation insurance claim)?

4. ... resulted from a motor vehicle accident (i.e. no fault insurance claim)?

5. ... recently been evaluated by a medical doctor?

Since this problem began, have you noticed...

No Yes

6. ... so much weakness in both your arms that you are unable to lift them?

7. ... so much weakness in both your legs that you are unable to walk without help?

8. ... difficulty controlling your bowel or bladder, or have you been unable to urinate?

9. ... pain in your chest, shortness of breath, or coughing up blood?

10. ... that one leg felt more warm, more swollen, more red, or more tender than the other?

Have you recently...

No Yes

11. ... had blurred vision, double vision, dizziness, or fainting?

12. ... had any type of infection, fever, or chills?

13. ... had any type of surgery, surgical procedure, or medical procedure?

14. ... lost a lot of weight without really trying to (i.e without being on a diet)?

15. ... had any type of accident, fall, or trauma?

Have you ever...

No Yes

16. ... been diagnosed with cancer?

17. ... been diagnosed with osteoporosis (i.e. weak, soft, or brittle bones)?

18. ... been diagnosed with a weakened immune system?

19. ... used any injected drugs (i.e. non-prescription drugs)?

20. ... used steroids such as prednisone for more than 4 weeks?

Is this problem something that ...

No Yes

21. ... you've had before?

22. ... generally gets worse (i.e more severe or frequent) with movement, activity, or exercise?

23. ... generally gets better (i.e. less severe or frequent) with rest?

24. ... was recently examined with diagnostic imaging tests such as x-rays, MRI scan, or CT scan?

25. ... is also being treated by a health professional other than a physical or occupational therapist?

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