

# Keeney Physical Therapy Intake

415 Pastoral Place • Sedona, AZ 86336

www.keeneyphysicaltherapy.com

503.452.7767

## Personal Information

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Email: \_\_\_\_\_  
DOB: \_\_\_\_\_ Gender: \_\_\_\_\_  
Who referred you? \_\_\_\_\_

## History

Exercise Frequency: \_\_\_\_\_ Exercise Type(s): \_\_\_\_\_  
Do you smoke? \_\_\_\_\_ Have you ever smoked? \_\_\_\_\_ How Often? \_\_\_\_\_  
Are you pregnant? \_\_\_\_\_ Do you have a Pacemaker? \_\_\_\_\_  
Allergies: \_\_\_\_\_  
What medications are you currently using? \_\_\_\_\_  
Previous complaints/surgeries: \_\_\_\_\_  
Previous diagnoses/medications: \_\_\_\_\_

## Complaint

Describe your primary complaints: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Start Date: \_\_\_\_\_ Possible Cause: \_\_\_\_\_  
Symptoms: \_\_\_\_\_  
Previous doctors seen for complaint: \_\_\_\_\_  
Previous treatment for complaint: \_\_\_\_\_  
Symptom-Aggravating Factors: \_\_\_\_\_  
Symptom-Relieving Factors: \_\_\_\_\_  
Time of Day Symptoms are Best: \_\_\_\_\_ Time They Are Worst: \_\_\_\_\_  
Current Duration of Pain:  Intermittent  Constant  With Certain Motions  
Current Level of Pain:  Mild  Moderate  Severe  Excruciating  
Is your pain getting better or worse? \_\_\_\_\_ Have you had this injury before? \_\_\_\_\_

## Do You Have Any of the Following Today? (Check All That Apply)

- |                                      |  |   |  |
|--------------------------------------|--|---|--|
| <input type="checkbox"/> AIDS/HIV    | <input type="checkbox"/> Anemia                  | <input type="checkbox"/> Angina                   | <input type="checkbox"/> Arteriosclerosis  |
| <input type="checkbox"/> Arthritis   | <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Blood Clots              | <input type="checkbox"/> Bone Infection    |
| <input type="checkbox"/> Cancer      | <input type="checkbox"/> Chemical Dependency     | <input type="checkbox"/> Circulation Problems     | <input type="checkbox"/> Depression        |
| <input type="checkbox"/> Diabetes    | <input type="checkbox"/> Epilepsy                | <input type="checkbox"/> Eye Infection            | <input type="checkbox"/> Heart Problems    |
| <input type="checkbox"/> Hemophilia  | <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Joint/Bone Infection     | <input type="checkbox"/> Liver Problems    |
| <input type="checkbox"/> Lung Issues | <input type="checkbox"/> Multiple Sclerosis      | <input type="checkbox"/> Musculoskeletal Problems | <input type="checkbox"/> Pneumonia         |
| <input type="checkbox"/> Stroke      | <input type="checkbox"/> STD                     | <input type="checkbox"/> Tuberculosis             | <input type="checkbox"/> Urinary Infection |

Signature \_\_\_\_\_

Date \_\_\_\_\_





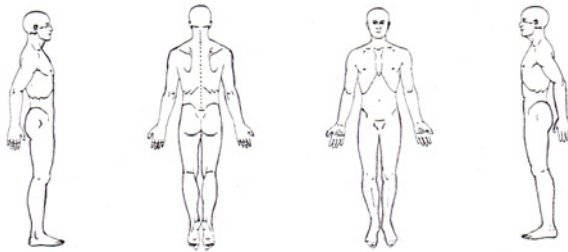
# Patient Intake Information

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

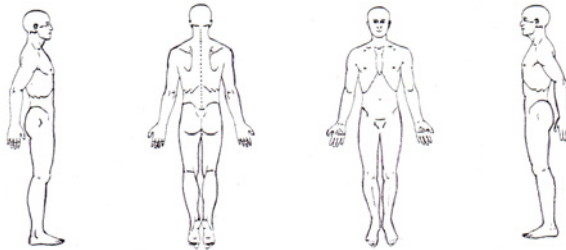
**Please complete the following information in detail This will assist in designing the most effective and efficient individualized program for you. Every item is significant and important. Thank you for your effort.**

Date of onset: \_\_\_\_\_

Pain Diagram: Please shade in all areas of pain. Be as thorough and specific as possible. Indicate the severity of pain on a scale of **0** = None to **10** = severe (excruciating) pain



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



Please state what you do for a living: \_\_\_\_\_

Briefly describe physical work requirements: \_\_\_\_\_

If you are currently not working:

How long have you not worked? \_\_\_\_\_

Are you not working for reasons other than you pain problem? \_\_\_\_\_

If so, what reason? \_\_\_\_\_

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

When do you anticipate returning to work? \_\_\_\_\_

Describe how your present living situation is different from the way it was before you first experienced pain/disability problems: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please indicate your present medical status, illnesses, diseases, fractures: \_\_\_\_\_

\_\_\_\_\_

What previous tests/ treatment have you received for condition(s)? (i.e. MRI, X-ray, physical therapy, chiropractic) \_\_\_\_\_

\_\_\_\_\_

List all past trauma (surgery, accidents, injuries), from birth to present, and when they occurred:

\_\_\_\_\_

List any other past diagnosed medical problems (i.e. diabetes, hepatitis, heart disease, cancer):

\_\_\_\_\_

Number of fillings (amalgams or composite): \_\_\_\_\_ Recent amalgam removal?  Yes  No

Number of Root Canals: \_\_\_\_\_ Number of crowns: \_\_\_\_\_

Number of known vaccinations (approximate): \_\_\_\_\_ Any parasitic diagnosis?  Yes  No

Any food poisoning?  Yes  No How many times? \_\_\_\_\_

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

Name: \_\_\_\_\_ Phone number: \_\_\_\_\_

Name: \_\_\_\_\_ Phone number: \_\_\_\_\_

Name: \_\_\_\_\_ Phone number: \_\_\_\_\_

Name: \_\_\_\_\_ Phone number: \_\_\_\_\_

List ALL medications you have taken recently (prescription & non-prescription):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### **Function: Sleep and Activity Level**

How many hours do you sleep at night?: \_\_\_\_\_

How many hours per day, (in 24 hours), do you spend out of bed?: \_\_\_\_\_

How would you consider your present level of activity? Poor Fair Good Excellent

Please list your present hobbies: \_\_\_\_\_

\_\_\_\_\_

Describe any regular exercises or sport you presently do: \_\_\_\_\_

\_\_\_\_\_

SYMPTOM	Never	Mild / Occasional	Moderate / Often	Severe / Constant
Dizziness, light-headed				
Nausea				
Ringing in ears, stuffy ears, painful ears				
Vision: blurring, aching, pressure, change in vision, double vision				
Decreased concentration / attention				
Short-term memory loss				
Sinus problems				
Cold hands				
Cold feet				
Stiffness				
Balance or coordination problems				
Bladder problems				
Sexual function problems				
Chest pain				
Sore that doesn't heal				
Unusual bleeding or discharge				
Thickening in breasts or elsewhere				
Indigestion				
Difficulty swallowing				
Nagging cough or hoarseness				
Headaches for hours a day				
Night sweats				
Pain in neck, jaw or face				
Drooping eyelid or any changes in pupils				
Slurred speech				
Faint / Pass out easily				
Snore				
Weight gain				
Weight loss				
Pain wakes you from sound sleep				

Allergies (please list and indicate frequency and severity):

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Indicate what makes your pain **worse**:  Walking  Driving  Running  Working  Time of day  Bending  Reaching  Squatting  Kneeling  Too much activity

Indicate what makes your pain **decrease**:  Walking  Driving  Running  Working  Time of day  Bending  Reaching  Squatting  Kneeling  Too much activity  Sitting  Lifting  Lying down  None / minimal activity

Other: \_\_\_\_\_

Please indicate your ability with the following activities:

ACTIVITY	Okay	Slightly Difficult	Great Difficulty	Slightly Painful	Severely Painful	Unable
Lie on back						
Lie on stomach						
Lie on right side						
Lie on left side						
Turn over back to stomach						
Turn over stomach to back						
Hands and knees						
Sit up from lying down						
Sit in a chair						
Sit on a sofa						
Sit in a car						
Look back while driving in reverse						
Lie down from sitting up						
Stand up from floor						
Stand up from chair						
Stand up straight						
Walk						
Run						
Bend (such as vacuuming)						
Lift objects from floor						
Lift objects from table						
Reach arms above head						
Dressing / undressing						
Bathroom and hygiene						
Sports						
Other:						
Other:						

I'll know I am better when: (Please give 10 specific answers)

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_
7. \_\_\_\_\_
8. \_\_\_\_\_
9. \_\_\_\_\_
10. \_\_\_\_\_