Keeney Physical Therapy Intake

Portland, OR 97223
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)

☐ AIDS/HIV	☐ Anemia	☐ Angina	☐ Arteriosclerosis
☐ Arthritis	☐ Asthma	☐ Blood Clots	☐ Bone Infection
☐ Cancer	☐ Chemical Dependency	☐ Circulation Problems	☐ Depression
☐ Diabetes	☐ Epilepsy	☐ Eye Infection	☐ Heart Problems
☐ Hemophilia	☐ High/Low Blood Pressure	☐ Joint/Bone Infection	☐ Liver Problems
☐ Lung Issues	☐ Multiple Sclerosis	☐ Musculoskeletal Problems	☐ Pneumonia
☐ Stroke	☐ STD	☐ Tuberculosis	☐ Urinary Infection

_____
Signature

_____
Date

Keeney Physical Therapy

Keeney Physical Therapy
A gentle path toward healing

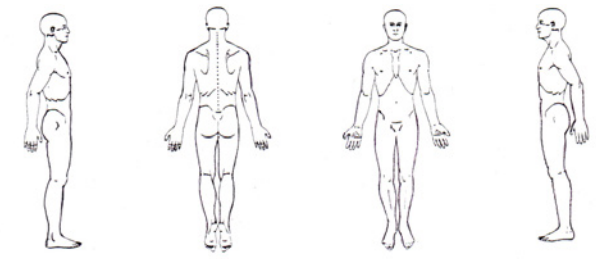
Patient Intake Information

Patient Name: _____ Date: _____
Age: _____ Height: _____ Weight: _____

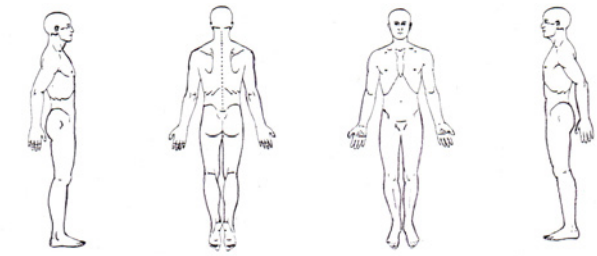
Please complete the following information in detail This will assist in designing the most effective and efficient individualized program for you. Every item is significant and important. Thank you for your effort.

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):

_____

_____

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. _____