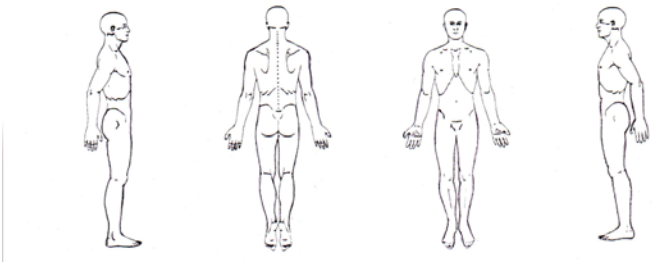
PATIENT INTAKE INFORMATION

Patient Name: _____ Date: _____

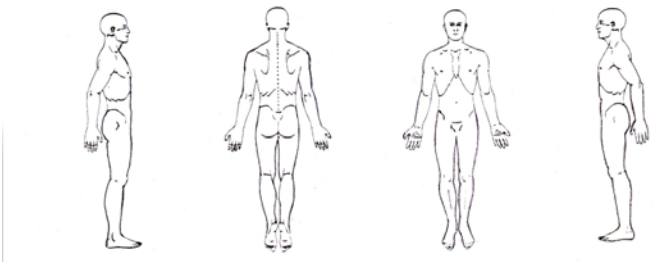
Age: _____Height: _____Weight: _____

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.

Under Oregon law, physical therapy requires a written, physician's referral after 30 days.
Referral: ☐ Yes ☐ No Referring Physician: _____
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 10 = severe, (excruciating) pain



Paresthesia Diagram: Please shade in all areas of " funny feelings", (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? _____

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

_____

_____

MEDICAL HISTORY

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. _____

Please list any other past diagnosed medical problems, (i.e. diabetes, hepatitis, heart disease, cancer. _____

Number of fillings, amalgams Or complete (please circle) Recent amalgam removal ☐ Yes ☐ No Number of Root Canals _____
Number of crowns _____

Number of known vaccinations, (approximate); _____

Any food poisoning? ☐ No ☐ Yes, How many times, _____ Any parasitic diagnosis? ☐No ☐ Yes

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: _____

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

1. _____ 2) _____

3) _____ 4) _____

5) _____ 6) _____

7) _____ 8) _____

9) _____ 10 _____

FUNCTION-SLEEP AND ACTIVITY LEVEL

How many hours do you sleep at night? _____

How many hours per day, (in 24hours), 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: _____

SYMPTOMS

Symptom	Never	Mild/ occasional	Moderate/ often	Severe/ Constant
Dizziness, light-headed				
Nausea				
Ringing 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 your 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 your pupils				
Slurred speech				
Pass out easily, (faint)				
Snore				
Weight Gain				
Weight Loss				
Pain wakes you from sound sleep				
Allergies, (please list below)				

1)_____ 2) _____ 3)_____

4) _____ 5) _____ 6) _____

Please indicate what makes your pain worse: ☐ Walking ☐Driving ☐Running ☐Working ☐Time of Day ☐Too much activity

☐ Bending ☐ Reaching ☐ Lifting ☐Squatting ☐ Kneeling

Please indicate what makes your pain decrease: ☐ Lying down ☐ Sitting ☐ Standing ☐ Walking ☐ Driving ☐ Running ☐ Working ☐ Time of day ☐ To much activity ☐ Bending ☐ Reaching ☐ Lifting ☐ Squatting ☐Kneeling ☐ None or minimal activit

☐ Other (specify): _____

Please indicate your ability with the following activities:

Activity	OK	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-stomach						
Turn over stomach-back						
Hands & Knees						
Sit up from lying down						
Sit in a chair						
Sit on a sofa						
Sit in a car						
Looking 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 & hygiene						
Sports						
Other: Please specify						
1)						
2)						
3)						
4)						

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

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____