

Physical/Hand Therapy INTAKE FORM



The Rehabilitation Center will strive to create the ultimate therapy experience. By providing an extension of your physician's expertise, we will effectively treat and manage orthopedic issues for the patients and families that we serve.

 First name Last name Date of birth

 Age Height Weight

 Date of next visit with referring doctor Primary care physician

 Employer Occupation

 Reason for referral

 Date of injury Date of surgery

 How symptoms are increased

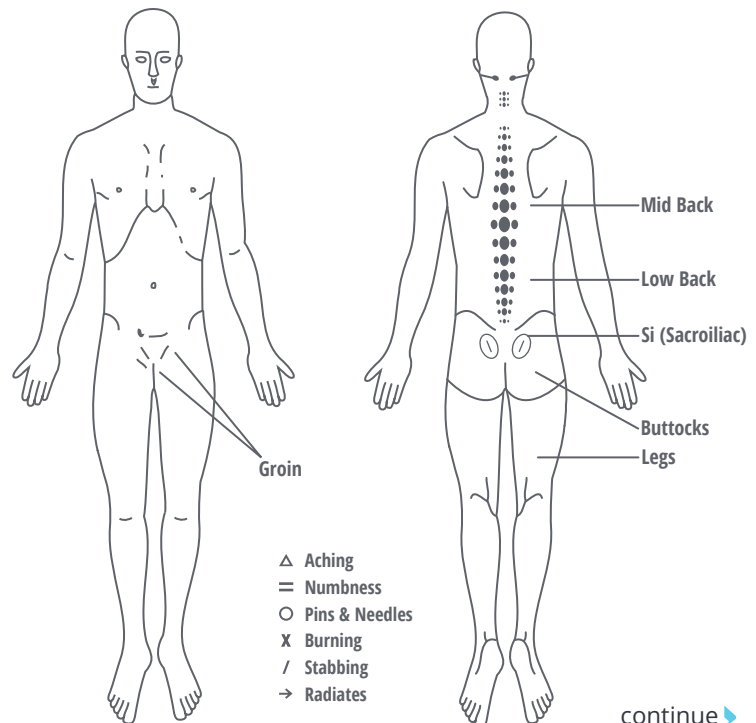
 How symptoms are decreased

List previous conditions or surgeries that may contribute to the current issue, then complete the model below for current nature of your pain using the provided symbols.

1 2 3 4 5 6 7 8 9 10

Pain Scale-Please mark level of pain on line above.

Please use the scale below to describe your pain location and quality.



continue ▶

Physical/Hand Therapy

INTAKE FORM

Please check if you have you **EVER** been diagnosed as having any of the following conditions:

- | | | | | |
|---|---|--|---|--------------------------------------|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Circulation problems | <input type="checkbox"/> Blood clots |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Asthma | <input type="checkbox"/> COPD/Emphysema | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Stomach Ulcers | <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> Depression | <input type="checkbox"/> Chemical dependency | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Other _____ | | |

Please list any medications that you are currently taking: (we can make a copy if you have a list)

Please check any of the following symptoms you are experiencing:

- | | | |
|--|---|--|
| <input type="checkbox"/> Night pain or night sweats | <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Tremors fever/chills/sweats | <input type="checkbox"/> Numbness or tingling | <input type="checkbox"/> Swelling |
| <input type="checkbox"/> Pain/problems blood in stools | <input type="checkbox"/> Sexual difficulties | <input type="checkbox"/> Skin rash |
| <input type="checkbox"/> Hearing problems | <input type="checkbox"/> Joint/muscle pain | <input type="checkbox"/> Eye redness |
| <input type="checkbox"/> Easy bruising | <input type="checkbox"/> Double vision loss of vision | <input type="checkbox"/> Excessive bleeding |
| <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Regular cough arm/leg swelling | <input type="checkbox"/> Nausea/vomiting |
| <input type="checkbox"/> Stress at home or work | <input type="checkbox"/> Bowel/bladder irregularities | <input type="checkbox"/> Difficulty swallowing |
| <input type="checkbox"/> Heartburn/indigestion | <input type="checkbox"/> Heart racing in your chest | <input type="checkbox"/> Post menopause |
| <input type="checkbox"/> Urinary incontinence | <input type="checkbox"/> Dizziness/lightheadedness | <input type="checkbox"/> Problems sleeping |
| <input type="checkbox"/> Weight loss/gain | <input type="checkbox"/> Pregnant or think you might be | <input type="checkbox"/> Abdominal pain |
| <input type="checkbox"/> Menstrual irregularities | <input type="checkbox"/> Fatigue | |

If you checked any of the above, are you under a physician's care for this/these conditions? Yes No

What is your goal for therapy?

Patient signature