Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**New Episode of Care Intake**

Kindly note why you are seeking skilled physical therapy today: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long have you had this condition for? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is this condition related to a fall? No Yes 🡪 Date: \_\_\_\_\_\_\_\_\_\_\_\_

Is this condition related to a car accident? No Yes 🡪 Date: \_\_\_\_\_\_\_\_\_\_\_\_

Did this condition occur at work? No Yes 🡪 Date: \_\_\_\_\_\_\_\_\_\_\_\_

Did you have any injections? No Yes 🡪 Date: \_\_\_\_\_\_\_\_\_\_\_\_

Have you had surgery for this condition? No Yes 🡪 Date: \_\_\_\_\_\_\_\_\_\_\_\_

Type of surgery: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had any other treatment(s)? No Yes 🡪 Date: \_\_\_\_\_\_\_\_\_\_\_\_

Please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is the primary goal you wish to achieve with skilled physical therapy?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please indicate your pain levels (0 is no pain and 10 is the worst pain)

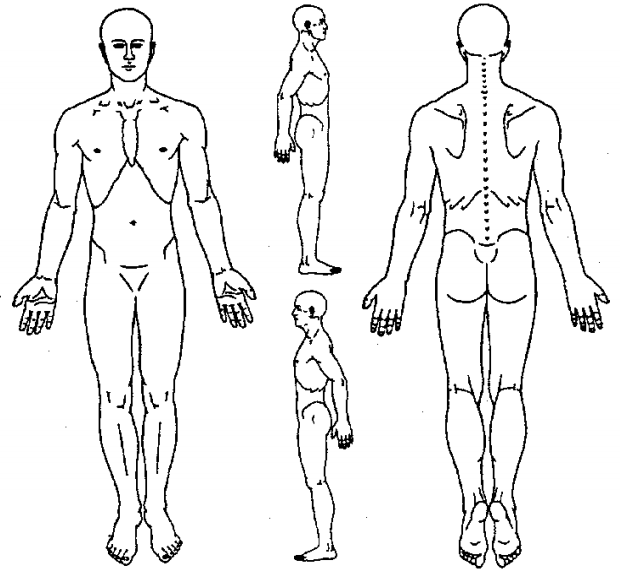
Current pain: \_\_\_\_\_\_\_ / 10 Pain at best: \_\_\_\_\_\_\_ / 10 Pain at worst: \_\_\_\_\_\_\_ / 10

(Please Check) Pain Frequency: Constant: \_\_\_ Intermittent: \_\_\_ Rare: \_\_\_ Random: \_\_\_

Pain descriptors: Sharp \_\_\_ Heavy \_\_\_ Dull \_\_\_ Cramping \_\_\_ Pressure \_\_\_ Burning \_\_\_

Tingling \_\_\_ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pain Location: Please indicate on the diagram below where you pain is located



**Past Medical History**

Do you have or have you had any of the following conditions?

Heart Disease: No Yes Circulation Problems: No Yes

Blood Clots: No Yes Respiratory Problems: No Yes

Asthma: No Yes Emphysema: No Yes

Bronchitis: No Yes History of Cancer: No Yes

Current Cancer: No Yes diabetes: No Yes

Fractures: No Yes Osteoarthritis: No Yes

Rheumatoid Arthritis: No Yes Sprains: No Yes

Muscle Strain: No Yes Osteoporosis: No Yes

Stroke: No Yes Parkinson's Disease: No Yes

Thyroid Problems: No Yes Kidney Problems: No Yes

Multiple Sclerosis: No Yes Anemia: No Yes

Chemical Dependency: No Yes Depression: No Yes

Fibromyalgia: No Yes Current Infection: No Yes

Alzheimer's Disease: No Yes Traumatic Brain Injury: No Yes

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

List any allergies (food, medication, latex)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you been feeling unsteady on your feet? No Yes

Have you fallen within the past 6 months? No Yes 🡪 # of times: \_\_\_\_\_\_\_

Have you used an assistive device or are currently using one? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you recently experienced any of the following? Comments

Unintended weight loss No Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Nausea or vomiting No Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fatigue No Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Weakness No Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fever, chills, sweats No Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Lightheadedness / dizziness No Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Numbness / tingling No Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Migraines / headaches No Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Shortness of breathing No Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you or were you a smoker? No Yes How many packs per day? \_\_\_\_\_\_\_

Do you consume caffeine? No Yes How many cup/can per day? \_\_\_\_\_

How often do you consume alcoholic beverages? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In the past month, have you felt depressed or hopeless? No Yes

In the past month, have you lost interest in doing things? No Yes

Have you felt unsafe in your home or has anyone tried to harm you? No Yes

WOMEN: Are you pregnant or could you be pregnant? No Yes

Have you had any of these tests within the past 6 months? Comments

X-Ray No Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Bone Scan No Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Doppler US No Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CT Scan No Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMG No Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NCV No Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MRI / MRA No Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there anything else you would like us to know? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient or Legal Guardian:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_