SPINESCOTTSDALE PHYSICAL THERAPY

Moving in the Right Direction

PATIENT INTAKE FORM

Name: _____ Date of Birth: _____Today's Date: _____

Primary Phone: _____ Secondary Phone: _____

Email Address: _____

SpineScottsdale Physical Therapy will use your e-mail to send newsletters, appointment reminders, and other physical therapy related information. If you do not give your permission for this e-mail correspondence, please indicate on the E-mail Address line above.

Emergency Contact: _____ Phone Number: _____

How did you choose SpineScottsdale Physical Therapy? _____

Referring Physician: _____ Primary Care Physician: _____

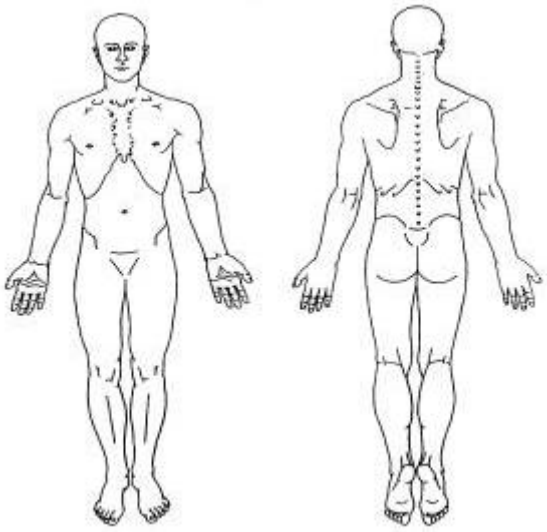
Do you have a follow up appointment with your referring physician? No:_____, Yes: _____(date)_____

Is this the result of an auto accident?: _____No_____Yes, date:_____ State where occurred: _____

**If yes, please provide our front office with auto insurance claim information

Have you had any other physical therapy in the current plan year? No____ Yes____

Are you currently receiving home healthcare (Medicare Only): No:____ Yes:____



HISTORY

Location of present symptoms: (please indicate on diagram) →

Date of Injury or Onset of Symptoms: _____

Cause of injury: _____ or no apparent reason: _____

Frequency of your symptoms (circle best response):

a. Constant (always there 24 hours per day)
b. Intermittent (symptoms fluctuate based on position or how you are moving)
c. Indicate what percent of day you notice your symptoms.

25% of day 50% of day 75% of day 100% of day

What **increases** your symptoms (circle all that apply):

Bending Sitting Sit to stand Standing Walking Lying Sleeping Turning head

A.M. / as the day progresses / P.M. When still / On the move Other:_____

What **decreases** your symptoms (circle all that apply):

Bending Sitting Sit to stand Standing Walking Lying Sleeping Turning head

A.M. / as the day progresses / P.M. When still / On the move Other:_____

Intensity of your symptoms: On a scale of 0 to 10, 0 meaning no pain and 10 meaning worst possible pain, please circle the number that best describes your symptoms:

Previous treatment for this condition: _____

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www.spinescottsdale.com

SPECIFIC QUESTIONS

List 3 important specific activities that you are having difficulty
Doing as a result of your problem, and rank your ability to perform. Unable → No Difficulty

1. _____ 0 1 2 3 4 5 6 7 8 9 10
2. _____ 0 1 2 3 4 5 6 7 8 9 10
3. _____ 0 1 2 3 4 5 6 7 8 9 10

What are your specific goals for therapy? _____

MEDICAL HISTORY

Do you have any dizziness/tinnitus/nausea/difficulty swallowing? Yes:_____ No:_____

Do you have pain or discomfort coughing/sneezing/straining? Yes:_____ No:_____

How is your bladder functioning? Normally _____ Abnormally _____

Please list **medications** you are taking for your current condition that you are being seen for.

1._____ Dosage? _____ How many pills per day? _____

2. ._____ Dosage? _____ How many pills per day? _____

3. ._____ Dosage? _____ How many pills per day? _____

Have you had any imaging for your current symptoms?

X-rays: Yes No Results: _____

MRI: Yes No Results: _____

Other: _____ Results: _____

Any unexplained night pain: Yes No Any unexplained weight loss: Yes No

Please list any recent or major surgeries with dates:

1._____ 2._____

Is there a possibility you are pregnant? Yes No

Do you currently have or have you had in the past any of the following?

Osteoporosis Yes No Cardiac/Heart Problems Yes No

Cancer Yes No Pacemaker/Defibrillator Yes No

Have you fallen more than once in the past year? Yes No

Have you fallen in the past year at least once resulting in an injury? Yes No

Is there anything else we should know? ____ No _____Yes: _____

Please circle the following that apply to you: I play golf I have osteoporosis I have a desk job I want to join a fitness facility

I understand that I am responsible to inform the physical therapist of any health problems and allergies I have, as well as any drugs or medications I am taking.

Patient Signature: _____ Printed Name: _____ Date: _____

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