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: ______________________________________

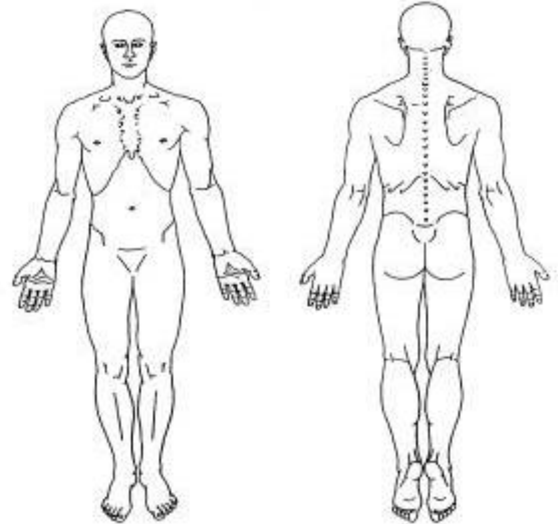
Do you have a follow up appointment with your referring physician? No:__________, Yes: __________(date)________________

Is this the result of an auto accident?:(circle one) No Yes, date:_______________ State where occurred: _________________

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. My pain is ***constant*** (always there 24 hours per day)

OR

b. My pain ***comes and goes***. I feel my symptoms (please circle):

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

**What <u>increases</u> your symptoms** (circle all that apply):

Bending Sitting Sit to stand Standing Walking Lying Sleeping Turning head

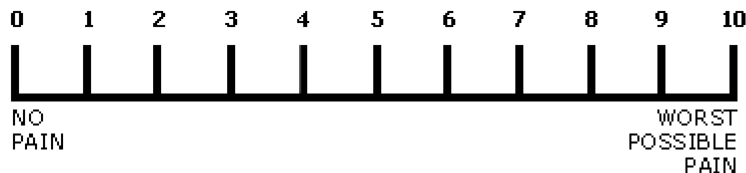
A.M. / as the day progresses / P.M. When still / On the move Other:_________________________________________

**What <u>decreases</u> 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: ___________________________________________________________________

**10277 N. 92nd St. Suite 103 Scottsdale, Arizona 85258**
**Phone (480) 584-3334 Fax (480) 272-9369**
**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:________________

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 orthopedic surgeries with dates:

1.______________________________________ 2.______________________________________

Is there a possibility you are pregnant? Yes No Please inform your therapist if this changes during course of treatment.

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

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Osteoporosis | Yes | No | Cardiac/Heart Problems | Yes | No | Spinal Stimulator | Yes | No |
| Cancer (currently) | Yes | No | Pacemaker/Defibrillator | Yes | No | Acute Inflammation | Yes | No |
| Kidney Stones | Yes | No | Spine Fusion | Yes | No | Thrombosis/Blood Clots | Yes | No |
| Severe Diabetes | Yes | No | Hip/Knee Replacement | Yes | No | Pulmonary Embolism | Yes | No |
| Cardiac Arrhythmia | Yes | No | Severe Migraines | Yes | No | Epilepsy | Yes | No |
| Seizures | 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: ________________________________________________________

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Are you interested in learning more about senior living? Yes No

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. I further understand that I am responsible to inform the physical therapist of any changes in your medical status during the course of treatment.

**Patient Signature:** ________________________________ **Printed Name:** __________________________ **Date:** __________