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NORTHEAST KINGDOM PHYSICAL THERAPY

PATIENT INTAKE NAME:_____

DATE: _____

The information you give us in this form will allow us to better treat you. This information is part of your medical record and is subject to state regulation on use and confidentiality. We may use this data anonymously for studies and to evaluate how well we're meeting your needs. If you have any questions about the content of this intake survey, please ask the receptionist or your therapist. Thank you.

Referring Physician _____

Primary Physician _____

Other Physicians or Health Practioners seen for this condition _____

Height _____ Weight _____ Age _____

Date of injury/Complaint_____ Body part injured _____

Describe the nature of your injury/complaint. Include date, where, and how it happened:

_____

_____

_____

PAIN:

On a scale of 0-10 (10 being the worst) how would you rate your pain today? _____
On a scale of 0-10, how is your pain at its worst? _____
On a scale of 0-10, what is the least pain you have experienced since your injury/complaint? _____

Are you out of work because of this injury/complaint? Yes _____ No _____

Are you on restricted duty because of this injury/complaint? Yes _____ No _____

What do you need to be able to do to return to full duty? (Describe you job requirements)

_____

_____

Are there any medical problems we should know about (Heart, lungs, cancer, fractures, blood pressure etc….) Please list:

_____

NORTHEAST KINGDOM PHYSICAL THERAPY

NAME: _____

Any Surgeries? Yes _____ No _____ If yes, please list: _____

_____

Any other major scars on your body? Please list: _____

Do you currently wear any splints, braces, orthotics, etc.? Please list_____

_____

Medical treatment you have received for your present condition, please explain _____

_____

Diagnostic studies which have been done for this condition, please list (i.e.: X-rays, MRI's Scans)

_____

_____

Are you presently taking any medication on regular basis? Yes _____ No _____

If yes, please list medication and explain what they are for: _____

_____

_____

HEALTH/FITNESS:

Has your physician ever advised you against exercise? Yes _____ No_____

If yes, please explain _____

How physically fit do you feel at the present?
Unfit _____ Below Average _____ Average _____ Above Average _____ Very Fit _____

Do you have any exercise equipment or devices at home? Yes _____ No _____

If yes, please list: _____

I have answered the preceding questions in the risk factor appraisal to the best of my ability. I understand all the questions asked of me and have been given the opportunity to have all my concerns clarified to my satisfaction. I understand that a thorough and honest response to these questions is essential to my safety and recommendation of the NorthEast Kingdom Physical Therapy Staff.

Signature _____ Date _____