# EXSTROM PHYSICAL THERAPY

3818 Normal Blvd., Lincoln, Nebraska 68506
P: (402) 488-4282 -- F: (402) 488-6157
www.ExstromPT.com

**Denise Exstrom Larsen**
**Physical Therapist**

**Jami Tomasek, DPT**
**Physical Therapist**

## PATIENT INTAKE

Please answer all questions clearly and completely and to the best of your ability

**PATIENT NAME:** ___________________________________ **DATE:** ____/____/____

1. **What physical and functional goals do you hope to achieve by coming to physical therapy?**

   ________________________________________________________________________________

   ________________________________________________________________________________

2. **If prior to your injury/surgery/diagnosis you felt 100%. What would you rate your percent function today?**
   **_______% / 100%**

3. **Please list any prescription, over the counter, vitamins, or herbs with dosages you are taking.**

   ________________________________________________________________________________

   ________________________________________________________________________________

4. **Please list any *surgeries/hospitalizations/motor vehicle accidents and other health conditions* you have had in your lifetime with *approximate month and year of occurrence/diagnosis*.**

   ________________________________________________________________________________

   ________________________________________________________________________________

   ________________________________________________________________________________

   ________________________________________________________________________________

   ________________________________________________________________________________

   ________________________________________________________________________________

   ________________________________________________________________________________

   ________________________________________________________________________________

5. **Have you experienced any of the following symptoms lately:**
   fatigue, dizziness/vertigo, nausea/vomiting, weakness, fever/chills/sweats, numbness/tingling, other _________

6. **What is your occupation/job title?** ______________________________ **Average hours per week worked** _____
   a. **What physical duties does it include?** ____________________________________________________

7. **Do you exercise?** ☐YES ☐NO
   a. **What types of exercises?** ____________________________________________________________
   b. **How often per week and how long per session?** ______________________________________________

8. **Do you have any hobbies?** ☐YES ☐NO
   a. **How often do you participate?** ______________________________________________
   b. **What is physically involved with your hobbies?**

   ______________________________________________________________

9. **Do you participate with any sports?** ☐YES ☐NO
   a. **Which sports?** ______________________________________________
   b. **How often do you participate with these sports?** ______________________________

10. **What daily activities are you physically involved with:**
   ☐ Lawn care ☐Cooking ☐Cleaning ☐Taking care of kids ☐Others:______________________

11. **Do you use tobacco products?** ☐YES – Smoking ☐YES – Smokeless ☐NO ☐PREVIOUS USER
   a. **How much and how often?** ________________________

12. **Do you drink alcohol?** ☐YES ☐NO ☐PREVIOUS USER
   a. **How much and how often?** ________________________

13. **Do you drink caffeinated beverages?** ☐YES ☐NO ☐PREVIOUS USER
   a. **How much and how often?** ________________________

14. **Do you use any recreational drugs?** ☐YES ☐NO ☐PREVIOUS USER
   a. **How much and how often?** ________________________

15. **How were you injured?** ______________________________________________
   a. **When were you injured?** _____/______/______
   b. **Do you have any X-rays, MRI's or special test results?** ☐YES ☐NO

16. **Were you referred to our office for rehab post surgery?** ☐YES ☐NO
   a. **What was the surgery?** ________________________________ **What was the Date?** _____/_____/_____

17. **What are the activities, movements, postures, and positions make symptoms worse?**

   ______________________________________________________________

18. **What things help decrease your symptoms and pain?**

   ______________________________________________________________

19. **Have you had any falls in the past year?** ☐YES ☐NO
   a. **How many and where?** ______Home ______Work ______While Out
   b. **Have any resulted in injury?** ☐ No ______Home ______Work ______While Out

# *****************STAFF USE ONLY*****************

**HEIGHT: _____ inches** **WEIGHT_____ pounds** **BLOOD PRESSURE _____/_____**

**PAIN RATING: TODAY _____** **BEST _____** **WORST _____**