EXSTROM PHYSICAL THERAPY

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Patient Intake

Patient Name: _____ **Today's Date:** _____

Date of Birth: _____

Occupation: _____ **Are you currently working?** Yes / No

Does your job require lifting? Yes / No **If so, how much (lbs)?** _____

What percent of your workday do you sit? _____ **%** **Stand?** _____ **%**

Are you a tobacco smoker? Never / Former / Current **If so, how many packs/day?** _____

Are you, or could you be, pregnant? Yes / No

What is your current exercise level? (circle one)

Sedentary Lightly Active Moderately Active Very Active Extremely Active

How many days/week do you perform a regular fitness routine? _____

How well do you sleep at night? (circle one) Very Good Good Fair Poor

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PAST MEDICAL HISTORY

Have you ever been told that you have or had any of the following (circle yes or no):

Cancer	Yes	No	Heart Disease	Yes	No
Diabetes	Yes	No	Kidney Disease	Yes	No
Stroke	Yes	No	Liver Disease	Yes	No
Asthma	Yes	No	Lung Disease (COPD)	Yes	No
Fibromyalgia	Yes	No	Osteoporosis	Yes	No
Osteoarthritis	Yes	No	High Blood Pressure	Yes	No
Rheumatoid Arthritis	Yes	No	Hepatitis (A, B or C)	Yes	No
Pacemaker	Yes	No	HIV	Yes	No

In the past 3 months, have you experienced any of the following?

Dizziness	Yes	No	Unexplained weight loss	Yes	No
Headaches	Yes	No	Changes in bowel/bladder	Yes	No
Depression	Yes	No	Fever/chills/sweats	Yes	No
Numbness/tingling	Yes	No	Unrelenting pain at night	Yes	No
Falls/poor balance	Yes	No	Change in appetite	Yes	No

Current Medications (current list can be given to the front desk to copy instead of writing here):

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

Past Surgical History (surgery & date):

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

PRIMARY COMPLAINT

When did your pain/symptoms start (approximate date)? _____

How did your pain start? _____

Are your symptoms currently (circle one): Getting Better / Getting Worse / About the Same

What makes your pain/symptoms better? _____

What makes your pain/symptoms worse? _____

Have you had a X-ray, MRI or other imaging study for this problem? Yes / No

If yes, what type of imaging? _____ **Where were they taken?** _____

What treatments have you received for this problem so far (ie: chiropractic, injection, etc)?

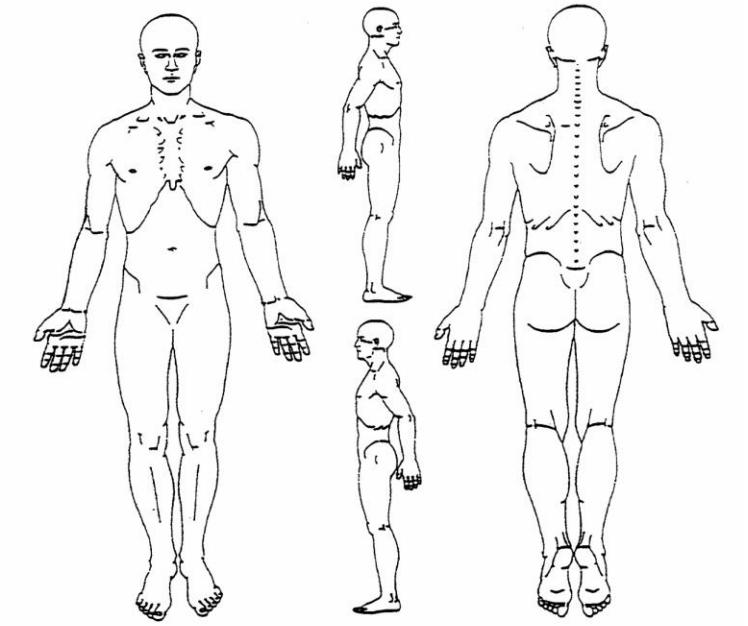
_____

Did you have surgery for this issue? Yes or No

If yes, what type of surgery? _____ **Date of surgery:** _____

Have you had similar pain/symptoms in the past? Yes / No **If so, when?** _____

BODY DIAGRAM: Please mark the areas where you feel pain on the chart below.



× Sharp pain

Dull pain or ache

••••••• Pins & needles or numbness & tingling

Shooting pain

Please mark the type and location of your pain on the body diagram.

Pain Scale: On this scale 0-10, please circle which number best represents your pain

At worst, my pain is:	No Pain	0	1	2	3	4	5	6	7	8	9	10	Worst Pain Imaginable
Currently, my pain is:	No Pain	0	1	2	3	4	5	6	7	8	9	10	Worst Pain Imaginable
At best, my pain is:	No Pain	0	1	2	3	4	5	6	7	8	9	10	Worst Pain Imaginable

On a scale from 0%-100% provided below, circle the percent of normal function at which you are currently able to perform. This includes: work performance, activity at home, sports, socially with friends, etc.

Able to do everything 100% 90% 80% 70% 60% 50% 40% 30% 20% 10% 0% Unable to do anything

Identify up to 3 important activities that you are unable to do or are having difficulty with as a result of your pain or symptoms:

1. _____

2. _____

3. _____

What are your personal goals for therapy at this time? _____

_____