

INITIAL EVALUATION INTAKE FORM (cont.)

Name: _____

(3) Have you ever had surgery? Yes No
If yes, please describe, and include dates:
Month Year

(4) **For men only:** Have you been diagnosed with prostate disease? Yes No

(5) **For women only:** Have you been diagnosed with:
 Pelvic inflammatory disease Endometriosis
 Trouble with your period Complicated pregnancies or deliveries
 Other gynecological or obstetrical difficulties
If yes, please describe: _____

19: CURRENT CONDITION(S) / CHIEF COMPLAINT(S)

(1) Describe the problem(s) for which you seek physical therapy: _____

(2) Have you experienced any of the following with your current problem? Locking Giving way Buckling
 Unconsciousness Lip numbness Dizziness/blurred
 Incontinence/difficulty urinating Dislocating
 Loss of balance dropping things
 Pain with cough/sneeze Numbness around groin/buttocks

(4) What is the frequency of your pain?
 Constant Less than 4X/day Greater than 4X/day
 Less than 4 X/week Greater than 4X/week No pain

(5) Does your pain awaken you at night? Yes No
If yes, how many times per night? 1 2 3 >3

(6) Do you have days or periods of time when you are completely pain free? Yes No

(7) When did these problem(s) begin? _____
Month Year

(8) Was the onset gradual? Yes No

(9) If there was an injury, describe the injury: _____

(10) Have you ever had the problem(s) before?
 No
 Yes
(a) What did you do for the problem(s)? _____
(b) Did the problem(s) get better? Yes No
(c) About how long did the problem(s) last? _____

(11) How is your current condition progressing overall?
 Improving Staying the same Getting worse

(12) What makes the problem(s) better? Heat Ice Rest
 Medication Change in position Exercise Other: _____

(13) What makes the problem(s) worse? sitting walking
 twisting bending squatting stairs rising from chair
push/pull standing kneeling reaching lifting reclining
 Other: _____

(14) Are you able to continue working? Yes, full duty
 Yes, light duty No Last day worked? Month Year

(15) Are you able to continue your usual recreational activities? Yes No Limited – Explain: _____

(16) Have you seen in the past, or are you currently seeing, anyone else for the problem(s) (check all that apply):

- Acupuncturist Orthopedist
- Chiropractor Osteopath
- Dentist Pediatrician
- Family practitioner Podiatrist
- Internist Neurologist/Neurosurgeon
- Massage Therapy Rheumatologist
- Obstetrician/gynecologist Psychiatrist
- Occupational therapist Rheumatologist
- Other: _____

20: MEDICATIONS

(1) Do you take any Physician-prescribed medications? (check all that apply)

- Aspirin Anti-inflammatories
- Advil/Aleve Muscle Relaxers (eg, Valium)
- Tylenol/acetaminophen Birth control pills
- Prescribed pain relievers High blood pressure medications
- Hormone replacement therapy Water pills (diuretics)
- Stomach ulcer pills Heart medications (other than for high blood pressure)
- Antibiotics Asthma medication
- Thyroid medication Insulin
- Antidepressant medication decongestants/antihistamines for sinus or allergy problems
- Seizure medication
- Other: Please list: _____

(2) Do you take any nonprescription medications?

- (check all that apply)
- Advil/Aleve Antacids (eg, Tums)
 - Motrin/Ibuprofen Decongestants
 - Antacids Herbal supplements
 - Ibuprofen/Naproxen Tylenol/acetaminophen
 - Antihistamines Other: Please list: _____
 - Aspirin
 - Tagamet, Zantac, Pepsid
 - Laxatives

(3) Have you taken any medications previously for the condition for which you are seeing the physical therapist?
 Yes No If yes, please list: _____

21: OTHER CLINICAL TESTS: Within the past year, have you had any of the following tests? (check all that apply)

- Angiogram Echocardiogram Spinal tap
- MRI EEG (electroencephalogram) Stool tests
- Arthroscopy EKG (electrocardiogram) Stress test (eg, bike or treadmill)
- Biopsy EMG (electromyogram) Urine tests
- Blood tests MRI X-rays
- Bone scan Myelogram
- Bronchoscopy NCV (nerve conduction velocity)
- CT scan Pulmonary function test Other: _____

THANK YOU!