ADULT NEW PATIENT INTAKE FORM **FUNCTION FIRST THERAPY, LLC**

PATIENT DEMOGRAPHICS

Patient Last Name: _____ First Name: _____

_____

Date of Birth: _____ Sex: ☐ Male ☐ Female

Referred By: _____ Reason for Referral: _____

_____

City: _____ State: _____ Zip Code: _____

_____

Primary Care Doctor: _____ Office Name: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship to Patient: _____

_____

Home/Cell Phone: _____ Work Phone: _____

_____

ABOUT ME

I am living: ☐ Alone ☐ Alone, but with assistance for my needs ☐ With an adult person ☐ With children in my home, ages_____

I am currently: ☐ Employed; my job is_____

☐ Unemployed ☐ On sick leave ☐ On disability ☐ Retired ☐ Work inside the home

☐ Waiting for disability

My physical activities include: ☐ Ready ☐ Watching TV ☐ Walking ☐ Gardening ☐ Housework

☐ Occasional physical exercise ☐ Regular physical exercise at least twice a week

I began having pain/symptoms around: _____/_____/_____

I have had this condition: ☐ Never till now ☐ Once before ☐ Many times before

My pain/symptoms were caused by (check all that apply):

☐ Accident or Injury, Explain:_____

☐ Surgery, Explain:_____

☐ Suddenly without reason ☐ Gradually worsening over time ☐ Due to change increase in activity

☐ Don't know

My symptoms are currently: ☐ Getting better ☐ Getting worse ☐ Staying about the same

What makes your symptoms worse? _____

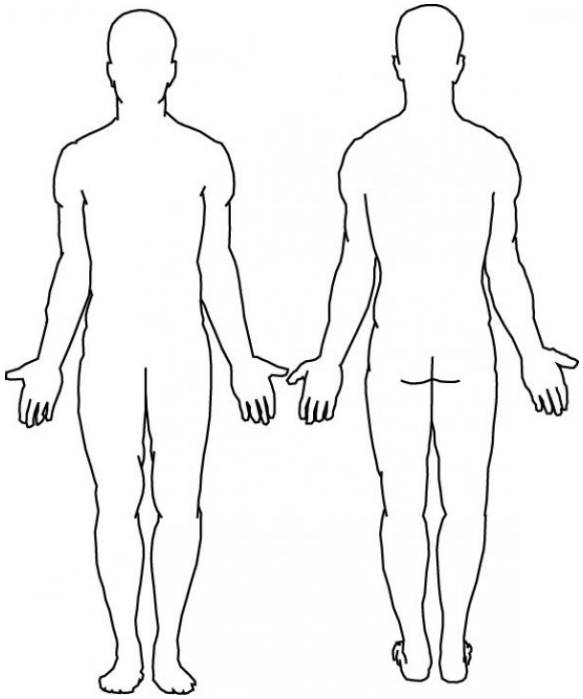
_____

What makes your symptoms better? _____

BODY CHART

On the chart to the right please mark the areas where you feel symptoms, by using the following symbols:

Shooting/sharp Pain	↓
Dull/aching pain	O
Numbness	=
Tingling	III



HEALTH HISTORY

I would rate my pain as:

Currently: _____/___10___ Least: _____/___10___ Worst: _____/___10___

ADULT NEW PATIENT INTAKE FORM **FUNCTION FIRST THERAPY, LLC**

Please list or provide a printed list of current medications and/or supplements:

Medication/Supplement	Dosage	Frequency Taken	Side Effects	Prescribing M.D.

Please list anything that you are allergic to and their reaction.

Food Allergies & reaction: _____

_____

Medications & reaction: _____

_____

Other: _____

_____

I have had these tests done recently: ☐ X-ray ☐ MRI ☐ CAT Scan ☐ Ultrasound ☐ Other _____

Please describe any results: _____

I have RECENTLY had the following symptoms (check all that apply):

☐ stiffness	☐ shortness of breath	☐ muscles weakness
☐ swelling	☐ fever/chills/sweats	☐ unexplained weight loss/gain
☐ pain at night	☐ bowel/bladder changes	☐ shortness of breath
☐ dizziness	☐ headaches	☐ confusion
☐ fainting	☐ fatigue	☐ pain radiating down arms
☐ nausea/vomiting	☐ fatigue	☐ difficulty sleeping
☐ spasms	☐ falls	☐ pain radiating down legs

ADULT NEW PATIENT INTAKE FORM **FUNCTION FIRST THERAPY, LLC**

I have or have had (check all that apply):

☐ cancer	☐ bladder/kidney problems	☐ plastic/metal implants
☐ arthritis	☐ high blood pressure	☐ liver problems
☐ heart condition	☐ diabetes	☐ thyroid problems
☐ chest pain	☐ circulation problems	☐ blood clots
☐ asthma	☐ depression/anxiety	☐ osteoporosis
☐ seizures	☐ lung problems	☐ pacemaker
☐ stroke	☐ ulcers	☐ fibromyalgia
☐ drug or alcohol abuse	☐ other _____	

☐ current smoker ☐ past smoker ☐ currently pregnant

During the past month, have you often been bothered by little interest or pleasure in doing things that you enjoy? ☐ Yes ☐ No

During the past month, have you often been feeling down, depressed or hopeless? ☐ Yes ☐ No

If yes, is it something you would like to have help with? ☐ Yes, but not today ☐ Yes ☐ No

Do you ever feel unsafe at home or any anyone hit you or tried to injure you in any way? ☐ Yes ☐ No

What activities are you having difficulty doing because of your pain or dysfunction? _____

_____

What is your personal goal for therapy? _____

_____

Is there any other information or concerns you would like to share with your therapist? _____

_____

FOR THERAPIST USE

☐ Oswestry ☐ Cervical Index ☐ DASH ☐ LEFS ☐ FABQ ☐ FAAM ☐ LYSHOLM ☐ Other_____

Therapist Signature: _____Date: _____