

PATIENT INTAKE FORM

Name: _____ Date of Birth: _____ Today's Date: _____

Primary Phone: _____ Secondary Phone: _____

Email Address: _____

SpineScottsdale Physical Therapy will use your e-mail to send newsletters, appointment reminders, and other physical therapy related information. If you do not give your permission for this e-mail correspondence, please indicate on the E-mail Address line above.

Emergency Contact: _____ Phone Number: _____

How did you choose SpineScottsdale Physical Therapy? _____

Referring Physician: _____ Primary Care Physician: _____

Do you have a follow up appointment with your referring physician? No: _____, Yes: _____ (date) _____

Is this the result of an auto accident?:(circle one) No Yes, date: _____ State where occurred: _____

Have you had any other physical therapy in the current plan year? No ___ Yes ___

Are you currently receiving home healthcare (Medicare Only): No: ___ Yes: ___

HISTORY

Location of present symptoms: (please indicate on diagram) →

Date of Injury or Onset of Symptoms: _____

Cause of injury: _____ or no apparent reason: _____

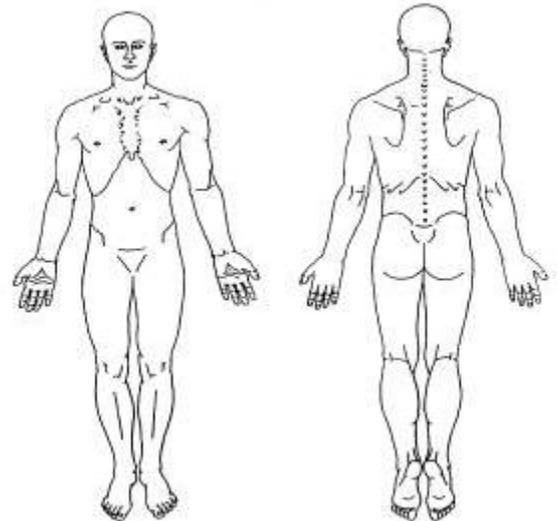
Frequency of your symptoms (circle best response):

- a. My pain is **constant** (always there 24 hours per day)

OR

- b. My pain **comes and goes**. I feel my symptoms (please circle):

25% of day 50% of day 75% of day



What increases your symptoms (circle all that apply):

Bending Sitting Sit to stand Standing Walking Lying Sleeping Turning head

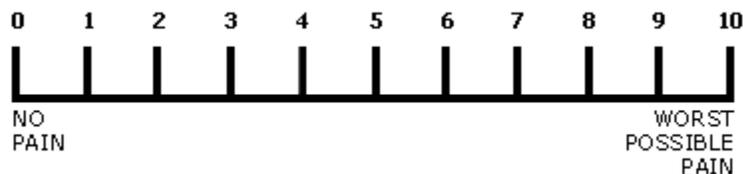
A.M. / as the day progresses / P.M. When still / On the move Other: _____

What decreases your symptoms (circle all that apply):

Bending Sitting Sit to stand Standing Walking Lying Sleeping Turning head

A.M. / as the day progresses / P.M. When still / On the move Other: _____

Intensity of your symptoms: On a scale of 0 to 10, 0 meaning no pain and 10 meaning worst possible pain, please circle the number that best describes your symptoms:



H:

W:

Previous treatment for this condition: _____

SPECIFIC QUESTIONS

List 3 important specific activities that you are having difficulty
Doing as a result of your problem, and rank your ability to perform.

Unable  No Difficulty

- | | |
|----------|------------------------|
| 1. _____ | 0 1 2 3 4 5 6 7 8 9 10 |
| 2. _____ | 0 1 2 3 4 5 6 7 8 9 10 |
| 3. _____ | 0 1 2 3 4 5 6 7 8 9 10 |

What are your specific goals for therapy? _____

MEDICAL HISTORY

Do you have any dizziness/tinnitus/nausea/difficulty swallowing? Yes: _____ No: _____

How is your bladder functioning? Normally _____ Abnormally _____

Have you had any imaging for your current symptoms?

X-rays: Yes No Results: _____

MRI: Yes No Results: _____

Other: _____ Results: _____

Any unexplained night pain: Yes No Any unexplained weight loss: Yes No

Please list any recent or major orthopedic surgeries with dates:

1. _____ 2. _____

Is there a possibility you are pregnant? Yes No Please inform your therapist if this changes during course of treatment.

Do you currently have or have you had in the past any of the following?

Osteoporosis	Yes	No	Cardiac/Heart Problems	Yes	No	Spinal Stimulator	Yes	No
Cancer (currently)	Yes	No	Pacemaker/Defibrillator	Yes	No	Accute Inflammation	Yes	No
Kidney Stones	Yes	No	Spine Fusion	Yes	No	Thrombosis/Blood Clots	Yes	No
Severe Diabetes	Yes	No	Hip/Knee Replacement	Yes	No	Pulmonary Embolism	Yes	No
Cardiac Arrhythmia	Yes	No	Severe Migraines	Yes	No	Epilepsy	Yes	No
Seizures	Yes	No						

Have you fallen more than once in the past year? Yes No

Have you fallen in the past year at least once resulting in an injury? Yes No

Is there anything else we should know? ___ No ___ Yes: _____

Are you interested in learning more about senior living? Yes No

Please circle the following that apply to you: I play golf I have osteoporosis I have a desk job I want to join a fitness facility

I understand that I am responsible to inform the physical therapist of any health problems and allergies I have, as well as any drugs or medications I am taking. I further understand that I am responsible to inform the physical therapist of any changes in your medical status during the course of treatment.

Patient Signature: _____ **Printed Name:** _____ **Date:** _____

