Morgan Mobile Therapy & Wellness ***Patient Intake Form***

Date: _____ Date of Birth: _____ NAME: _____

1° Emergency Contact: _____ Phone: _____

Relationship: _____ Please add additional at end of form.

HISTORY OF CURRENT CONDITION

1. CHIEF COMPLAINT/AILMENT/INJURY _____

2. DATE OF INJURY_____ DATE OF SURGERY _____

3. Briefly describe how you were injured if applicable: _____

_____

4. Indicate ALL diagnostic tests or treatments that apply which you have had for your current diagnosis.

__Physical therapy	__Traction	__MRI	__EMG	__Home Health
__Acupuncture	__Exercise	__X-Ray	__Hospitalization	__Injection
__Massage Therapy	__Yoga	__CT Scan	__Casting/Bracing Boot	__Medication
__Chiropractic Care	__Bed Rest	__Bone Scan		

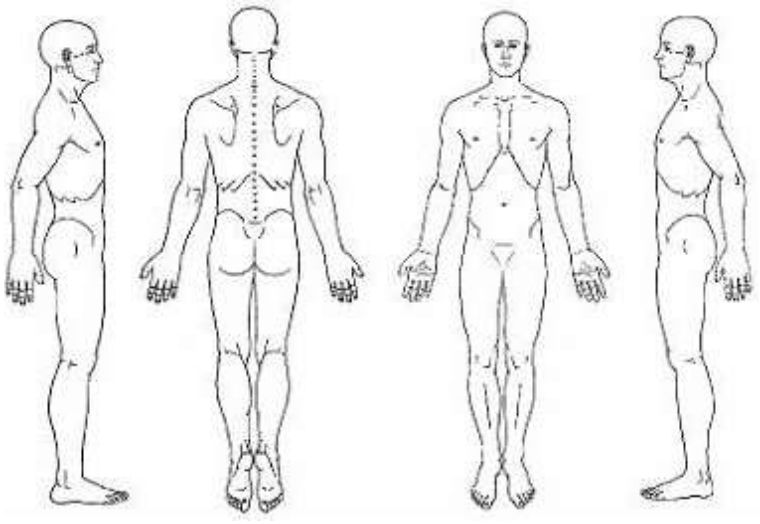
What results have you seen so far with the treatments you have indicated above? _____

_____

5. Please circle the number that best corresponds to your pain/intensity of your symptoms in the past 24-hours.

AT BEST:	(No Pain)	0	1	2	3	4	5	6	7	8	9	10 (EXCRUCIATING PAIN)
AT WORST:	(No Pain)	0	1	2	3	4	5	6	7	8	9	10 (EXCRUCIATING PAIN)
TYPICALLY:	(No Pain)	0	1	2	3	4	5	6	7	8	9	10 (EXCRUCIATING PAIN)

DRAW IN AREAS OF PAIN ON BODY DIAGRAMS USING APPROPRIATE SYMBOLS.



SEVERE PAIN	*****
MODERATE PAIN	XXXXX
RADIATING PAIN	↓↑↓
NUMBNESS/TINGLING	ZZZZZZ

6. Have your symptoms been getting… BETTER WORSE SAME

7. Are your symptoms… CONSTANT OR INTERMITTENT

8. Please indicate ALL of the following which *increases your symptoms* or makes your condition ***WORSE***?

__BENDING	__SITTING	__WORSE IN AM	__HEAT
__MOVEMENT	__STANDING	__WORSE IN PM	__ICE
__REST	__RISING	__WORSE AS DAY PROGRESSES	__MEDICATION
__WALKING	__LYING	__CHANGING POSITION	__COUGH
__STAIRS	__PROLONGED POSITIONING	__DEEP BREATH	__SNEEZE

9. Please indicate ALL of the following which *decrease your symptoms* or makes your condition ***BETTER***?

__BENDING	__SITTING	__BETTER IN AM	__HEAT
__MOVEMENT	__STANDING	__BETTER IN PM	__ICE
__REST	__RISING	__BETTER AS DAY PROGRESSES	__MEDICATION
__WALKING	__LYING	__CHANGING POSITION	__N/A

10. Please briefly describe 2-3 ways your chief complaints affect how you function in your life.

1. _____

2. _____

3. _____

11. Have you ever had physical therapy in the past for this or another condition? YES OR NO

Please indicate your satisfaction with the previous outcome:

(POOR RESULT/NO IMPROVEMENT) 1 2 3 4 5 (GREAT RESULT/COMPLETE RECOVERY)

12. What activities are you hoping to be able to return to after you have completed Physical Therapy that you cannot do now? Please list 2-3 goals:

1. _____

2. _____

3. _____

How did you hear about us? _____

If referred, may we thank you referred you? YES OR NO

Emergency Contact: _____ Phone: _____

Relationship: _____

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