Patient Intake Sheet

Date: ________________

Patient Name: ______________________________________**Age:** _______ **Height** _________ **Weight**_______**Lbs.**

Chief Complaint: ____ **Injury side** : ☐ **Left** ☐ **Right**

History of Injury: ____

Surgery: ☐ No ☐ **Yes If Yes: Date**:_______________ **Type**:____

Limitations: ☐ Self Care ☐ Mobility Walking & Moving Around

☐ Changing & Maintaining Body Position ☐ Carrying, Moving Handling Objects

Pain Scale: 0=None 5=Moderate 10=Extreme

Current: 0 1 2 3 4 5 6 7 8 9 10 **At Worst**: 0 1 2 3 4 5 6 7 8 9 10

At Best: 0 1 2 3 4 5 6 7 8 9 10 **Pain:** ☐Sharp ☐ Dull ☐Achy ☐Burning ☐Throbbing

What makes it worse? ____

What makes it better? ____

Occupation/Work Status: ☐ Working ☐ Student ☐ Retired ☐ Other __________________________________

Medical History:

Previous Treatments for Similar Symptoms: ☐ Yes ☐ No ***If yes please explain***:_____________________

☐ No known significant previous medical history to affect treatment

☐ Alzheimer's ☐Parkinson's ☐Lupus ☐ History of Cancer _____________________________

☐ Cardiovascular Disease: ☐ Pacemaker ☐ Atrial fibrillation

☐ Multiple Sclerosis ☐ Osteoarthritis ☐ Rheumatoid Arthritis ☐ Diabetes: ☐Type1 ☐Type 2

☐ Fibromyalgia ☐Other: ____

Current Medication & Dosages:____

____

Diagnostic Testing: ☐ X-Ray ☐ MRI ☐ CT-Scan ☐Doppler ☐EMG

Surgical History: ____

____

Patient Goals:____