KLEIMAN & STAMPER PHYSICAL THERAPY

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Patient Intake Form

Patient's Name:____Date of birth: ____________

SSN______________________________ Sex: □ Female □ Male □ Non-Binary

Home Phone______________________________Work phone _________________________

Cell Phone: ___________________________ Contact Preference: □Home □Work □ Cell

E-mail Address ____

Marital Status: □ Single □ Married □ Divorced □ Widowed

Emergency Contact ____________________________Relationship___________________

Emergency Contact Phone ____

Mailing Address ____

City_________________________State_______________________Zip____________

Billing Address____□ Same as Mailing

City_________________________State_______________________Zip____________

Employer:____________________________Primary Physician: ___________________________

Referring Physician:____

Patient Signature: ____________________________________ Date: _______________________

Parent/Guardian Signature:___________________________ Relationship: ______________

Patient Questionnaire/Health History

Patient Name:____Date: _________________________________

To ensure your receive a complete and thorough evaluation, please provide us with the important background informationon the following form. If you do not understand the question, your therapist will assist you. Thank you!

IF YOU HAD AN ACCIDENT, PLEASE COMPLETE THIS SECTION

Date of accident___________□ Auto □ Work □ Other State in which injury occurred _____

Claim number___________________Insurance company (worker's comp or auto PIP) ____________________
Address______________________________Claims Adjuster__________________Phone # _____________

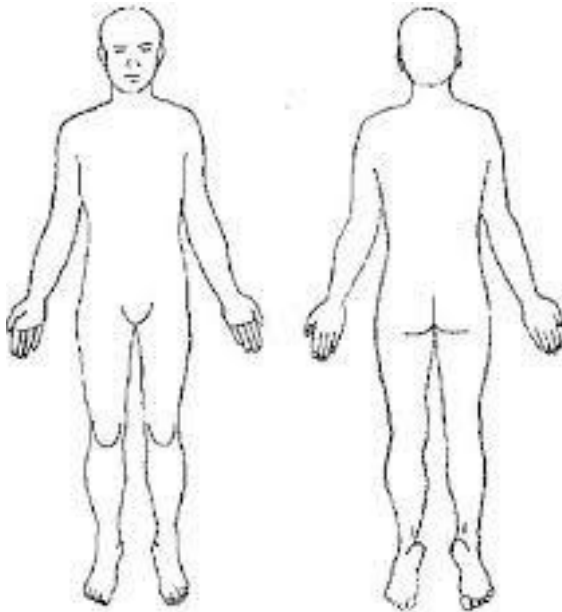
Referring Provider:__________________________

History of Present Condition:

What are your current symptoms? ____________________

____
____
____
____

Please indicate the area of pain or abnormal sensation on the body chart below (shade in the appropriate area)



When did your symptoms begin? ____________________

Was onset gradual or sudden : □ Gradual □ Sudden

Since onset are symptoms getting:
□ better □ worse □ not changing

Have you had similar symptoms in the past? YES NO

Have you had more than one episode? YES NO

Which of the following best describes how your injury occurred? (If your condition is post-surgical, please indicate as per original injury)

□ Lifting
□ Blow to the face
□ MVA (car accident)
□ Throwing
□ A fall
□ An incident at work
□ Overuse (cumulative trauma)
□ Degenerative process
□ During recreation/sports
□ Unknown
□ Trauma
□ Other

Nature of pain/symptoms (check all that apply)

□ sharp □ aching □ constant
□ dull □ periodic □ other _______________
□ throbbing □ occasional ______________________

Throughout the day do your symptoms: (check one)

□ increase □ decrease □ stay the same

Does the pain wake you at night? YES NO

Since onset of your current symptoms have you had:

□ any difficulty with control of bowel or bladder function
□ fever/chills
□ any numbness in the genital or anal area
□ numbness in arms or legs
□ any dizziness or fainting attacks
□ weakness
□ unexplained weight change
□ night pain/sweats
□ malaise (vague feeling of bodily discomfort)
□ problems with vision/hearing
□ none of these

Have you had any previous treatment for this condition?

____

Have you had any imaging done? (x-rays, MRI, CT scan)

____

What aggravates your symptoms? (check all that apply)

- □ sitting
- □ going to/rising from sitting
- □ lying down
- □ walking
- □ up/down stairs
- □ reaching overhead
- □ reaching in front of body
- □ reaching behind back
- □ reaching across body
- □ talking, chewing, yawning
- □ repetitive activities
- □ household activities
- □ standing
- □ squatting
- □ sleeping
- □ coughing/sneezing
- □ taking a deep breath
- □ looking up overhead
- □ swallowing
- □ stress
- □ recreational sports including
- □ sustained bending
- □ other: ___________________________________

What relieves your symptoms? (check all that apply)

- □ sitting
- □ heat
- □ cold
- □ stretching
- □ wearing a splint/orthosis
- □ rest
- □ standing
- □ walking
- □ exercise
- □ lying down
- □ massage
- □ medication
- □ nothing
- □ other ______________ ________________

Medication

Please list any prescription medications you are currently taking (pain pills, injections and/or skin patches, etc.):

____

____

____

____

____

General Health

How would you rate your general health?

□ Excellent □ Good □ Average □ Poor

Do you exercise outside of normal daily activity?

- □ 5+ days/wk
- □ 3-4 days/wk
- □ 1-2 days/wk
- □ occasionally
- □ none

Exercise, Sports/Recreation consists of:_____________

Past Medical History

Have you ever been diagnosed with any of the following conditions? (check all that apply)

- □ Cancer (type)_____________
- □ Depression
- □ Stroke
- □ Kidney problems
- □ Thyroid problems
- □ Diabetes
- □ Multiple Sclerosis
- □ Head injury
- □ Stomach problems
- □ Parkinson's disease
- □ Infectious diseases
- □ Arthritis
- □ Heart problems
- □ High blood pressure
- □ Lung problems
- □ Blood disorders
- □ Epilepsy/seizures
- □ Allergies
- □ Rheumatoid arthritis
- □ Osteoporosis
- □ Broken bones
- □ Circulation/vascular problems
- □ Other _____________

Do you smoke? If yes, how much?___________________

____

Are you currently pregnant? ________________________

Work History

Occupation:______________________________________

Physical Activities at work (check all that apply)

- □ sitting
- □ standing
- □ phone use
- □ repetitive lifting
- □ heavy lifting
- □ computer use
- □ heavy equipment operation
- □ driving
- □ other ___________________

Are you currently receiving or seeking disability for thiscon-dition?

YES NO

If not performing your normal activities at work, do you plan to RETURN to your previous activity level?

YES NO