



PHYSICAL REHAB DEPT
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INITIAL PHYSICAL THERAPY/CHIRO INTAKE HISTORY

DATE: _____

REFERENCE: _____
CLAIM#: _____
DOI: _____
EMPLOYER AT DOI: _____
ADJUSTER: _____ FAX: _____
REFERRING PHYSICIAN: _____ FAX: _____
ATTORNEY: _____ FAX: _____

PATIENT IDENTIFICATION:

HISTORY OF PRESENT INJURY: (as related by the patient)

- 1. What is the area of injury?
2. What is the type of injury? Specific / Cumulative
3. What is the mechanism of injury? Lifting / Fall / Repetitive Trauma / Twisting / Blunt injury / Other
4. What treatment and/or diagnostic studies have you received? (please circle all that apply)
5. How is your injury progressing? Worsening / Unchanged / Improving

CURRENT COMPLAINTS:

- 1. Where is the area of pain?
2. What is your average level of pain on a scale of 0 to 10?
3. What best describes the quality of the pain? (Please circle all that apply)
4. What is the frequency of the pain? (Please circle all that apply)

- | | | | |
|--|-------------------|-------------------------|------------------------------|
| | Constant Mornings | intermittent Afternoons | with Weight bearing Evenings |
|--|-------------------|-------------------------|------------------------------|
5. Does the pain radiate? Yes / No
What location does it radiate to? _____
 6. Do you experience numbness or tingling? Yes / No
Where do you experience the paresthesias? _____
 7. What factors or activities aggravate your pain? (Please circle all that apply)

Coughing	Sneezing	Bowel Movements	Sitting
Standing	Walking	Bending	Lifting
Crawling	Overhead Activities	Repetitive use of arms	Keyboarding
Cold Weather	Stress		
 8. What factors or activities relieve your pain? (Please circle all that apply)

Laying	Sitting	Standing	Walking
Rest	Medications	Heat	Ice
Massage	TENS	Injections	
 9. Do you experience bladder or bowel incontinence? Yes / No

PAST SURGICAL HISTORY: PLEASE CIRCLE ALL THAT APPLY

- | | | | |
|-----------------------|------------------------|---------------------|------------------|
| Appendectomy | Cholecystectomy | Tonsillectomy | Hernia Repair |
| Carpal Tunnel Release | Laparoscopy | Cervical Fusion | Lumbar Fusion |
| Lumbar discectomy | Lumbar Laminectomy | Hip Replacement | Knee Replacement |
| Coronary Angioplasty | Coronary Artery Bypass | Hysterectomy | C-section |
| Gastric Bypass | Arthroscopy | Rotator Cuff Repair | Breast Implants |

PAST MEDICAL HISTORY: PLEASE CIRCLE ALL THAT APPLY

- | | | | |
|---------------------------------|------------------|----------------------|----------------|
| Diabetes | Hypertension | Elevated Cholesterol | Heart Disease |
| Hepatitis | Kidney Disease | Gout | Osteoporosis |
| Hyperthyroidism | Hypothyroidism | Migraine Headaches | Fibromyalgia |
| Depression | Anxiety Disorder | Bipolar Disorder | Systemic Lupus |
| Rheumatoid Arthritis | HIV | Peptic Ulcer Disease | Asthma |
| Congestive Heart Failure | Sleep Apnea | Emphysema | |
| Gastroesophageal Reflux Disease | | Cancer (Type _____) | |
| Other _____ | | | |

DRUG ALLERGIES: PLEASE CIRCLE ALL THAT APPLY

No known drug or food allergies.

- | | | | |
|------------|-------------|--------|----------|
| Penicillin | Latex | Sulfa | Iodine |
| Shellfish | Aspirin | NSAIDs | Morphine |
| Vicodin | Other _____ | | |

CURRENT MEDICATIONS:

HABITS:

1. Do you smoke or chew tobacco? Yes / No
How many packs per day? _____ How many years? _____

2. Do you drink alcohol? Yes / No
How frequently? Rarely / Occasionally / Daily
3. Do you use illegal drugs? Yes / No (If yes, please circle all that apply)
Cocaine Marijuana Heroin Methamphetamines
Amphetamines Ecstasy

SOCIAL HISTORY:

1. What is your marital status? Single / Married / Separated / Divorced
2. Do you have any children? Yes / No
How many? _____
3. What is your living situation? Live alone / Live with roommate(s) / Lives with family

FAMILY HISTORY:

Father / Mother is deceased.

Does anyone in your immediate family have any medical illnesses? Yes / No (Please circle all that apply and specify **F**-Father, **M**-Mother, **B**-Brother, and **S**-Sister next to the diagnoses)

- | | | | |
|----------------------|---------------------|----------------------|----------------|
| Diabetes | Hypertension | Elevated Cholesterol | Heart Disease |
| Hepatitis | Kidney Disease | Gout | Osteoporosis |
| Hyperthyroidism | Hypothyroidism | Migraine Headaches | Fibromyalgia |
| Depression | Anxiety Disorder | Bipolar Disorder | Systemic Lupus |
| Rheumatoid Arthritis | Cancer (Type _____) | | |
| Other _____ | | | |

JOB DESCRIPTION:

1. What is your occupation? _____
2. Who is your employer? _____
3. How long have you been employed with the above employer? _____
4. Is this a work related injury? _____
5. What is your current work status? Full Duty / Modified Duty / Off Work
6. How long have you been on modified duty or off work? _____

PREVIOUS INJURIES: RELATED TO THIS CURRENT PROBLEM

REVIEW OF SYSTEMS:

The patient admits to experiencing...(see circled symptoms).
The patient denies any...

- | | | | |
|------------|---------------------|--------------------|--------------|
| Chest Pain | Shortness of Breath | Nausea | Vomiting |
| Fevers | Chills | Excessive Sedation | Constipation |
| Diarrhea | Insomnia | Weight Loss | Weight Gain |
| Headaches | Heartburn | Excessive Sweating | Leg swelling |