PHYSICAL REHAB DEPT

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INITIAL PHYSICAL THERAPY/CHIRO INTAKE HISTORY

DATE: _____________

REFERENCE: ______________________
CLAIM#: ______________________
DOI: ______________________
EMPLOYER AT DOI: ______________________
ADJUSTER: ______________________
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)

Medications	Physical Therapy	Occupational Therapy	Acupuncture
Massage Therapy	Chiropractic	TENS / Stimulator	Psychological counseling
Joint Injections	Radiographs	MRI /CT Scan	Electrodiagnostic Studies
Trigger Point Injections		Epidural Injections	Surgery

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)

Burning	Stinging	Stabbing	Aching
Electrical	Shooting	Pressure	Throbbing
Sharp	Dull	Piercing	Grinding

4. What is the frequency of the pain? (Please circle all that apply)

Constant	intermittent	with Weight bearing
Mornings	Afternoons	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 diskectomy	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