TAOS PHYSICAL THERAPY INTAKE FORM

PATIENT INFORMATION

NAME_____ BIRTHDATE_____

PHONE NUMBER_____EMAIL _____

CURRENTLY EMPLOYED? YES NO MODIFIED

OCCUPATION_____ EMPLOYER_____

REHAB INFORMATION

1. CHIEF COMPLAINT/AILMENT/INJURY _____
2. DATE OF INJURY_____ DATE OF SURGERY_____
3. BRIEFLY DESCRIBE HOW YOU WERE INJURED

   _____

   _____
4. HAVE YOU RECEIVED THERAPY OR OTHER MEDICAL CARE /TREATMENT FOR THIS CONDITION? YES NO

   WHAT TYPE?_____ WHEN?_____ HOW MANY VISITS?_____
5. HAS YOUR CONDITION BEEN GETTING: WORSE SAME BETTER
6. ARE YOUR SYMPTOMS: CONSTANT OR INTERMITTENT
7. MARK THE NUMBER THAT BEST CORRESPONDS TO YOUR PAIN:

   AT BEST: 0 1 2 3 4 5 6 7 8 9 10 (EXCRUCIATING PAIN)

   AT WORST: 0 1 2 3 4 5 6 7 8 9 10 (EXCRUCIATING PAIN)
8. WHAT DECREASES/MAKES YOUR CONDITION BETTER? (EXAMPLE: LAYING DOWN)

   _____

   _____
9. WHAT INCREASES/MAKES YOUR CONDITION WORSE? (EXAMPLE: REACHING FOR THE HIGH SHELF)

   _____

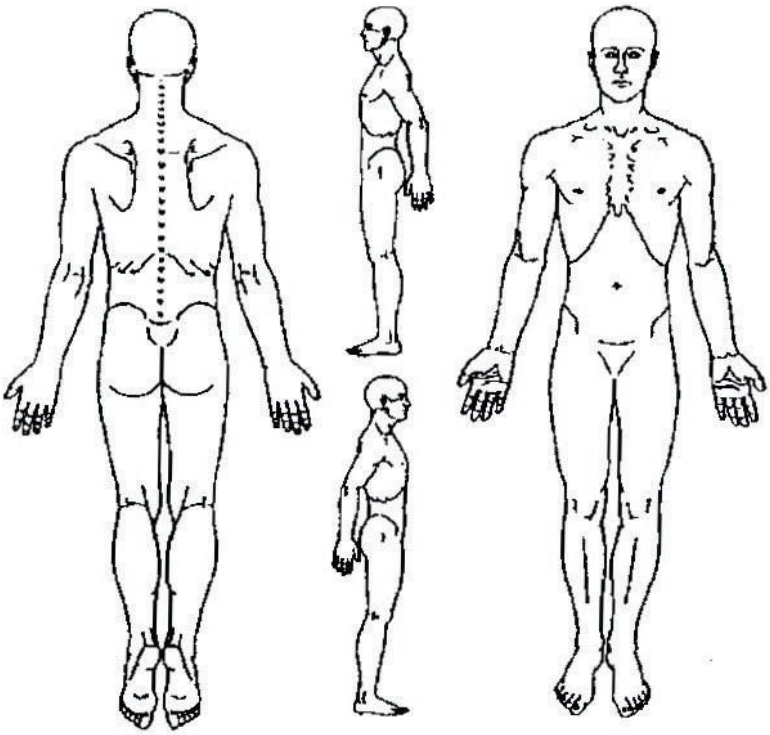
   _____
10. PREVIOUS TESTING AND DIAGNOSTICS (MARK ALL THAT APPLY)

    ☐ X-RAY ☐ MRI ☐ CAT SCAN OTHER_____
11. WHAT ARE YOUR GOALS TO BE ACHIEVED BY THE END OF THERAPY?

    _____

    _____

SHADE IN AREAS OF PAIN ON BODY DIAGRAMS. If you are completing this form on the computer, print form after completion and mark the diagram with a pen.



FOR OFFICE USE ONLY:

BLOOD PRESSURE:_____

PULSE:_____

OXYGEN:_____

HEIGHT:_____

WEIGHT:_____

BMI:_____

OUTCOME MEASURE:_____

MEDICAL INFORMATION (CIRCLE ALL THAT APPLY)

DIFFICULTY SWALLOWING	MOTION SICKNESS	STROKE
ARTHRITIS	FEVER/CHILLS/SWEATS	OSTEOPOROSIS/OSTEOPENIA
HIGH BLOOD PRESSURE	UNEXPLAINED WEIGHT LOSS	ANEMIA/BLOOD DISORDER
HEART TROUBLE	BLOOD CLOTS	BLEEDING PROBLEMS
PACEMAKER	SHORTNESS OF BREATH	HIV/HEPATITIS/CONTAGIOUS DISEASE
EPILEPSY/SEIZURES	HISTORY OF SMOKING	HISTORY OF ALCOHOL ABUSE
HISTORY OF DRUG ABUSE	DIABETES	DEPRESSION/ANXIETY
MYOFASCIAL PAIN	FIBROMYALGIA	PREGNANCY
CANCER: TYPE_____	EATING DISORDER	HEARING PROBLEM
VISION PROBLEM		

PREVIOUS SURGERIES:_____

_____

MEDICATIONS/DOSAGES:

_____

ALLERGIES:_____

SIGNATURE:_____DATE:_____