Rehab Patient Intake Form

Date: _____

Name: _____ Age: _____ Birth Date: _____ Gender: M F

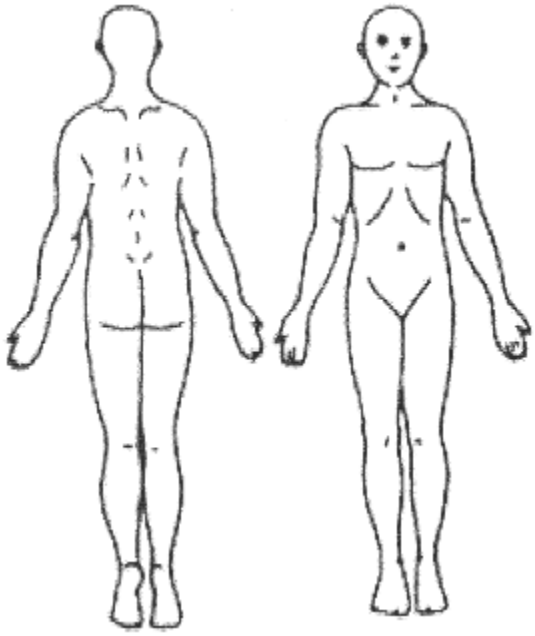
Present Health Concerns: Please list your most important health concerns in their order of significance.

Complaint (Low back pain, shoulder, headache, etc.)	**Date of Onset or Duration**	**What Prior diagnosis?**	**Constant or Intermittent**	**Getting better, worse or no change?**	**Severity** 1-10 (10=stops all activity)	**Medications / Treatments**
1.						
2.						
3.						
4.						

Other Health Concerns and Diagnosis: _____

Description of Symptoms:

Key:
T=Tingling
N=Numbness
M=Mild pain
Mod=Mod Pain
S=Severe
SS=Sharp Shooting
X= Trigger Points Tenderness



Please mark the areas of complaints using the key above

What **goals** do you have for your visit today? _____

What Prior Treatment have you had for your top conditions? When? _____

Mechanism of Onset: (Describe)_____

___Auto (circle): Driver, Passenger, or Pedestrian

___Work Related: ___ Fall ___ Impact from Object ___ Lifting ___ Other_____

___Repetitive Motion ___Slept wrong ___ Overexertion ___Slip/Fall ___ Other _____

___Unknown cause/etiology (No known injury)

___Other (liability): ___Slip or fall Other_____

Symptom Effect on Daily Activities:

ACTIVITY	Level of Pain (1-10)	Little Effect	Severe (Unable to Perform)
Resting			
Walking			
Position Change (Sit/Stand)			
Self-Care (Feeding, Bath,			
Driving			
Extended sitting/computer			
Sleep			
Dressing/Shaving			
Household chores/yardwork			

Sexual Activity			
Climbing Stairs			
Lifting			
Kneeling or bending			

Feels Better with (ie: cold, warm, etc): _____

Feels Worse with (ie: cold, warm, etc): _____

Any Associated Symptoms? (Circle all that apply): Vision, dizziness, ringing in ears, local tingling, burning, numb, weakness, swelling, spasm, nausea, sleep disturbance, depression, panic, other: _____

Radiation? Left / Right / Bilateral **Weakness?** Left / Right / Bilateral

Headaches: Location: _____ Quality (sharp, dull, throb): _____Types: _____

WORK HISTORY:

Job Title: _____ How long _____

Job duties: [] Sit without break for _____minutes. [] Computer work [] Assembly/Hand tool use
[] Forward bend/stoop without break for____min. [] Stand without break for ___minutes.
[] Lift over _____ pounds [] Lift over head [] from floor

Surgical History: Mark or List all surgical procedures with the DATE of procedure.

OPERATION/HOSPITALIZATIONS (Include Tonsillectomy and Appendectomy)

Date	Type	Complications

Injury History:

SEVERE ACCIDENTS INJURIES

_____ Date: _____
_____ Date: _____

_____ Date: _____
_____ Date: _____

Social History Affecting Healing (sleep, tobacco, exercise): _____

_____