# Holistic Occupational and Physical Therapy

## Outpatient Rehabilitation Intake Form



| | |
|---|---|
| PATIENT NAME: | |
| MR #: | DOB: |
| REFERRING PHYSICIAN: | |
| DIAGNOSIS: | |

### HISTORY OF CURRENT CONDITION

*For Office Use Only*

**1) What is the primary reason for coming to therapy?** *(Please check all that apply)*

☐pain ☐weakness ☐decreased joint range of motion ☐a fall or multiple falls
☐difficulty performing activities of daily living (such as bathing, dressing, self care)

_____

☐ difficulty walking ☐ other *describe:*_____

**2) When did this problem(s) begin?**_____

**3) What is the cause of your condition?**_____

☐traumatic incident ☐work related ☐motor vehicle accident
☐no obvious Incident ☐gradual onset ☐sudden onset ☐chronic condition
☐other *describe:*_____

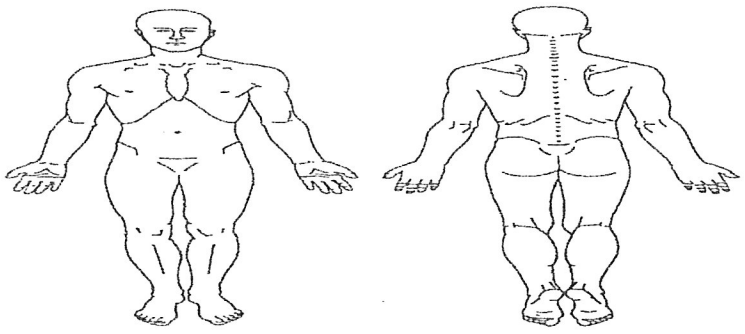
**4)Work Status:** ☐working full duty ☐out of work ☐retired
☐working modified duty *describe:*_____
*Occupation:*_____

**5) Have you had previous** ☐Physical Therapy ☐Occupational Therapy ☐other:_____
*If yes, please state when and why:*_____

**6) What are your goals for therapy?** _____

**7) Where is the pain/ problem?** *( indicate by marking on the picture below)*

**Front** **Back**



**Right Left** **Left Right**

**8)** Which word(s) describe your pain *(check all that apply)*

| | | | | | |
|---|---|---|---|---|---|
| ☐aching | ☐gnawing | ☐penetrating | ☐shooting | ☐unbearable | ☐occasional |
| ☐burning | ☐nagging | ☐radiating | ☐stabbing | ☐other *(describe below)* | ☐continuous |
| ☐exhausting | ☐numb | ☐sharp | ☐throbbing | _____ | ☐intermittent |

**9) Over the past 24 hours, what number best describes your pain…**

*(Rate your pain by circling one number below)*

**at rest?** *(No Pain)* **0 1 2 3 4 5 6 7 8 9 10** *(Worst Pain Possible)*
**with activity?** *(No Pain)* **0 1 2 3 4 5 6 7 8 9 10** *(Worst Pain Possible)*

**10) What Diagnostic tests have you undergone?** *(check all that apply)* ☐none
☐x-ray ☐MRI ☐CT-scan ☐EMG ☐other *describe:*

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### PAST MEDICAL HISTORY

***Please supply details of ALL medical problems. If you do not have the condition, mark "no".***

**Heart:** ☐no ☐yes: ☐heart attack ☐angina ☐pacemaker ☐irregular heart rate ☐congestive heart failure ☐other *(describe)*_____

**Lung:** ☐no ☐yes: ☐asthma ☐bronchitis ☐emphysema ☐other *describe:*_____

**Blood Pressure:** ☐no ☐yes: ☐high ☐low What your usual BP?_____

**Diabetes:** ☐no ☐yes: ☐insulin dependent ☐diet controlled ☐oral controlled

**Bone or Joint:** ☐no ☐yes:
☐osteoporosis ☐arthritis ☐fractures *describe:*_____
☐spine surgery ☐joint replacements *describe:*_____

**Cancer**: ☐no ☐yes: *Type/ Location:*_____
☐Chemo/ Radiation Treatment: *Date/ Complications:*_____

**Kidney/Liver:** ☐no ☐yes: ☐dialysis *type:*_____
☐hepatitis A B C *(circle)* ☐**other** *describe:*_____

**Neurological:** ☐no ☐yes:
☐stroke ☐parkinsons ☐multiple sclerosis ☐head injury ☐seizures

**Immunosuppression:** ☐no ☐yes: ☐HIV ☐other *describe:*_____

**Have you had a history of resistant organisms or previous precautions?** ☐no ☐yes:_____

**Psychological:** ☐no ☐yes: ☐anxiety ☐depression ☐other *describe*:_____

**Allergies:** ☐no ☐yes: ☐latex ☐food ☐other *describe:*_____

**Nutritional:** Weight loss/ gain >10 lbs in 6 months ***yes/no***
TPN/ tube feeding ***yes/no***
Problems chewing/ swallowing ***yes/no***
Other *describe:*_____

Do you **Smoke** ☐no ☐yes, how much?_____ **Drink** ☐no ☐yes, how much?_____

**Have you experienced any of the following?**
Visual deficits ***yes/no*** Dizziness ***yes/no*** Fainting spells ***yes/no*** Falls ***yes/no***

**Females:** Is there a chance that you may be pregnant? ☐**no** ☐**yes:**_____ **months**

**SURGERIES:** _____

**Medications:** ***Please list all medications that you are currently taking*** **including** ***prescription medications, over the counter medications, and/or vitamins/ herbals.***
**As medications change or are added, please notify your therapist each visit.**

***The above supplied information is accurate and complete, I understand withholding relevant medical history may compromise my therapy. As other conditions arise I will update my therapist.***

**Patient Signature:** **Date:**

**Therapist Signature:** **Date/Time:**

***For Office Use Only***

***Updates***
**(Include Intials/ Date)**