OUTPATIENT REHABILITATION INTAKE SUMMARY

Name:_____ Date of Birth:_____ Today's Date:_____

Describe the problem that brings you to therapy: _____

Date problem began: _____

What is your goal for therapy? _____

Have you received therapy for any type of injury since January 1st? ❑ Yes ❑ No

Do you have pain? ❑ Yes ❑ No

If yes, please indicate areas and type of pain with the following symbols:

SHARP
XXXX

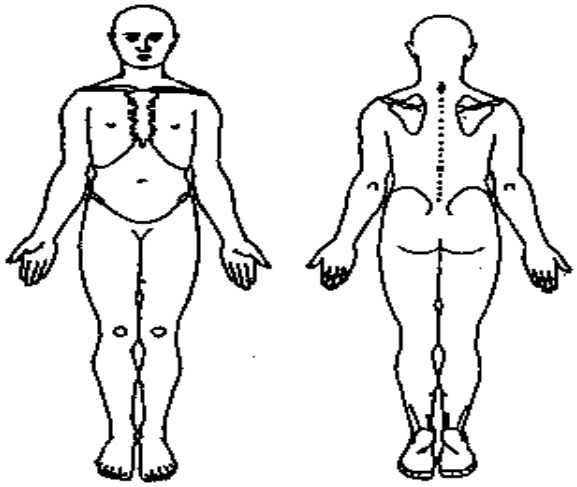
DULL
OOOOOO

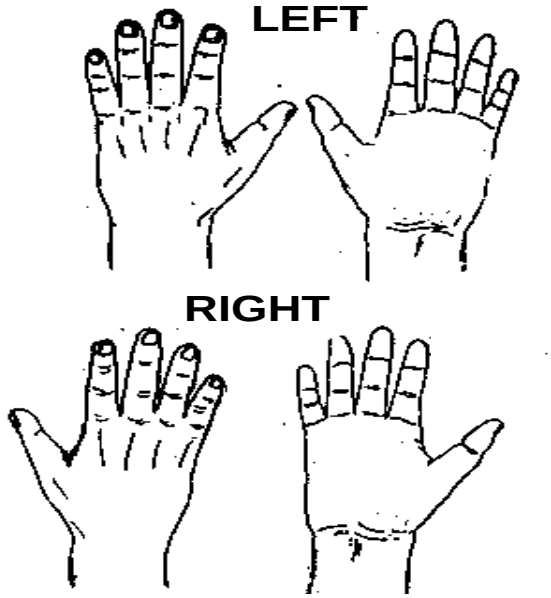
ACHING
✓✓✓✓✓✓

NUMBNESS
□□□□□

TINGLING
••••••••••••

BURNING
// // // // //





Have you had any tests recently? (X-Ray, MRI, CT Scan, etc.)_____

Describe what you do to keep physically fit:_____

Do you live with: ❑ Spouse ❑ Child(ren) ❑ Parent(s)/Guardian ❑ Alone ❑ Other: _____

Are you currently working? ❑ Yes ❑ No Occupation: _____

Is there anything else you think your therapist will need to know?: _____

Past Medical History: Do you have any previous history of the following conditions?

High Blood Pressure:	❑ Yes	❑ No	Severe Emotional Disturbance:	❑ Yes	❑ No
Heart Condition/Pacemaker:	❑ Yes	❑ No	Persistent Night Pain:	❑ Yes	❑ No
Strokes:	❑ Yes	❑ No	Cancer:	❑ Yes	❑ No
Diabetes:	❑ Yes	❑ No	Respiratory Disorders/Short of breath:	❑ Yes	❑ No
Broken Bones (Fractures):	❑ Yes	❑ No	Excessive Fatigue:	❑ Yes	❑ No
Metal Implants:	❑ Yes	❑ No	Frequent/Severe Headaches:	❑ Yes	❑ No
Arthritis:	❑ Yes	❑ No	Unexplained Weight Loss/Gain:	❑ Yes	❑ No
Fibromyalgia:	❑ Yes	❑ No	Change in Bowel/Bladder Function:	❑ Yes	❑ No
Seizures:	❑ Yes	❑ No	Any communicable disease:	❑ Yes	❑ No

Are you pregnant now or is there a chance you could be? ❑ Yes ❑ No

Have you taken steroids for a prolonged period of time? ❑ Yes ❑ No

→→→→→→→ OVER →→→→→→→

OUTPATIENT REHABILITATION INTAKE SUMMARY

Languages you speak: ❑ English ❑ American Sign Language ❑ Spanish ❑ Other _____
Preferred language for discussing healthcare: ❑ English ❑ American Sign Language ❑ Spanish ❑ Other _____

Preferred Mode of communication: ❑ Verbal ❑ Sign Language ❑ Written ❑ Other_____

ALLERGIES Do you have any allergies? ❑ No ❑ Yes, please list:	**REACTION**

OTHER DIAGNOSES AND/OR SIGNIFICANT CONDITIONS Do you have any other diagnoses or significant conditions? ❑ No ❑ Yes, please list:	**Staff Use Only** **Time**	**Date**	**Signature**

PREVIOUS PROCEDURES / SURGERIES Did you have any other previous procedures / surgeries? ❑ No ❑ Yes, please list:	**Staff Use Only** **Time**	**Date**	**Signature**

CURRENT MEDICATIONS, INCLUDING HERBALS Are you currently taking any medications, including herbals? ❑ No ❑ Yes, please list:	**Staff Use Only** **Time**	**Date**	**Signature**
❑ See attached list			

If I am being evaluated by a Physical Therapist without a physician referral, I understand that any diagnosis made is a therapy diagnosis and not a medical diagnosis. I acknowledge that the above is true to the best of my knowledge and am aware that if I miss three scheduled visits within the course of treatment that my treatment may be discontinued per therapist discretion.

_____ _____ _____
Patient Signature Date Time