Olender Physical Therapy

Strength in Motion • www.olenderphysicaltherapy.com

Patient Intake Form

Date: _____

Name: _____ Birthdate: _____

Reason for Care: _____

_____

When and how did the symptoms start?: _____

_____

Quality of Symptoms/Pain (Check all that apply):

( ) Achy ( ) Dull ( ) Stiff ( ) Sharp ( ) Constant ( ) Off/On ( ) Throbbing ( ) Shooting

( ) Burning ( ) Stabbing ( ) Numb ( ) Tingling ( ) Burning ( ) Other

What makes the symptoms worse?: _____

_____

What makes the symptoms better?: _____

_____

Does the problem radiate to other parts of your body?: _____

Any functional problems on a daily basis? (Dressing, Chores): _____

_____

What were you able to do before this injury that you can't do now?: _____

_____

What is your pain level from 0-10? (0=None,10=Severe):

Best: _____Worse: _____Usual: _____

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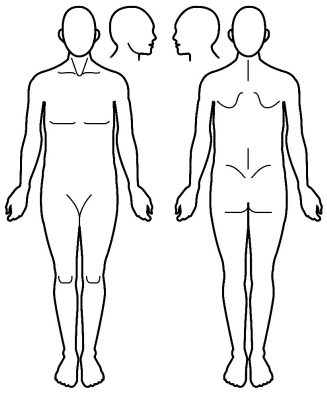
Using the diagram below, circle or shade in the areas of pain:



Front **Back**

Please list any falls, car accidents, fractures, sprains, strains: _____

_____

_____

Please list all exercises, recreational activities and hobbies: _____

_____

Goals
What do you hope to achieve with care?: _____

_____

Review of Systems:
Please check all of the conditions that you have had or are currently experiencing.

Musculoskeletal

( ) Neck Pain ( ) Back Pain ( ) Shoulder Pain ( ) Elbow/Hand Pain ( ) Hip Pain

( ) Knee/Ankle Pain ( ) Arthritis ( ) Scoliosis ( ) Osteoporosis

Last Bone Scan Date: _____

Neurological

( ) Headaches ( ) Migraines ( ) Anxiety ( ) Depression ( ) Sleep Problems