

# Intake Form

To insure you receive a complete and thorough evaluation, please provide us with this important background information.

Name: \_\_\_\_\_

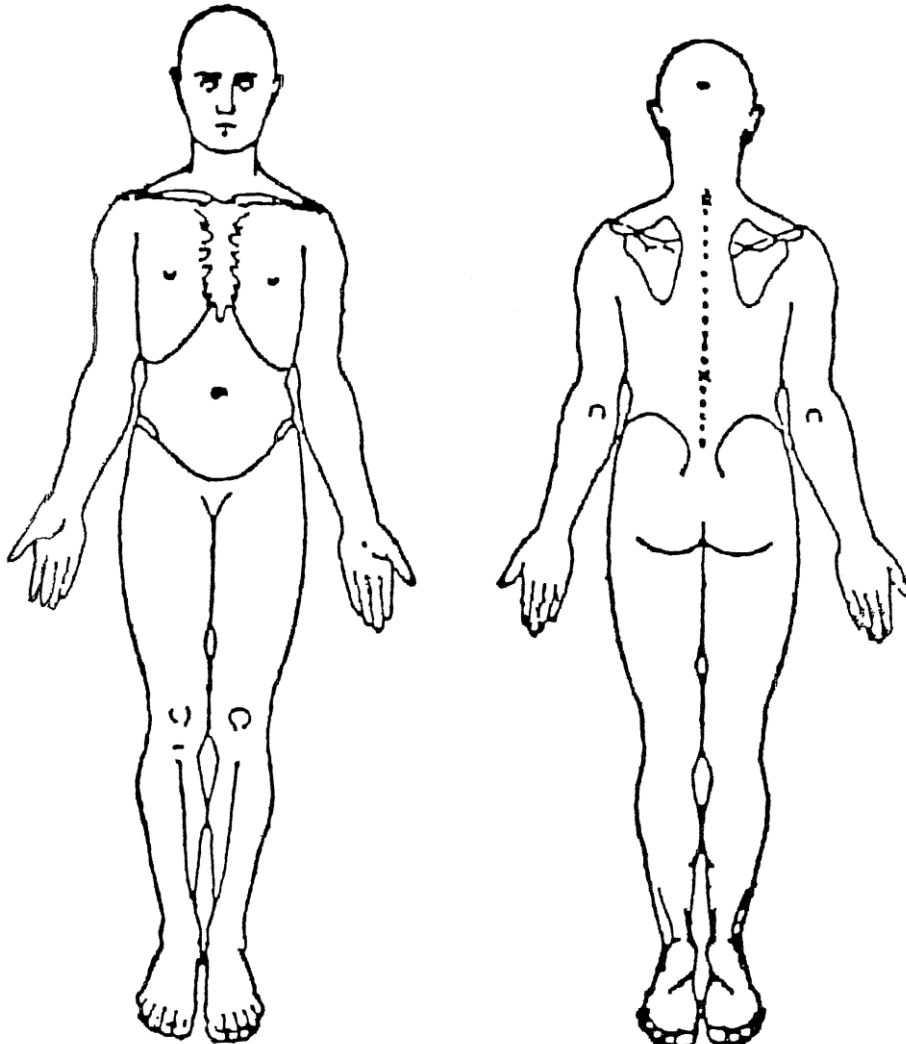
Age: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

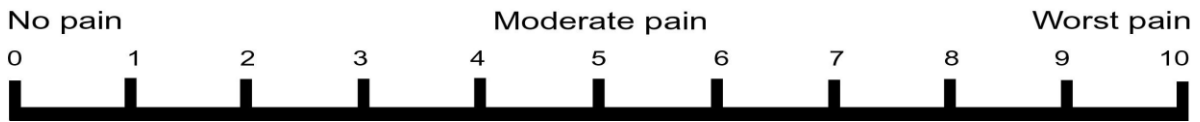
Chief Complaint: \_\_\_\_\_

Do you have any pain?    Yes     No

If yes, please mark the areas on the drawings below.



**On the following scale of 0 – 10, how would you rate your pain?**



**Pain is:**  constant  intermittent \_\_\_\_\_

**Do you have other symptoms?**

- swelling  stiffness  weakness  tenderness  tightness
- limited motion  numbness  tingling sensation
- others: \_\_\_\_\_

**Due to your condition do you have difficulty:**

- walking  balancing
- sleeping  getting up from bed/chair
- personal care activities (dressing, washing, etc.)
- performing work duties
- performing light domestic duties
- performing heavy domestic duties
- performing your recreation/ sport activities
- commuting/ traveling

During the past month, have you often been bothered by feeling down, depressed or hopeless? Yes  No

During the past month, have you often been bothered by little interest or pleasure in doing things? Yes  No

What makes your pain increase? \_\_\_\_\_  
\_\_\_\_\_

What, if anything, eases your pain? \_\_\_\_\_  
\_\_\_\_\_

Do you have night pain?    Yes             No

**Current Medications:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**MEDICAL HISTORY**

*Have you ever had any of the following?*

- |                |                        |                     |                          |
|----------------|------------------------|---------------------|--------------------------|
| ___ Anemia     | ___ Fractures          | ___ HIV             | ___ Pacemaker            |
| ___ Asthma     | ___ Headaches          | ___ Insomnia        | ___ Rheumatoid arthritis |
| ___ Cancer     | ___ Heart attack       | ___ Kidney problems | ___ Tuberculosis         |
| ___ Chest pain | ___ Heart disease      | ___ Low back pain   | ___ Seizures             |
| ___ Depression | ___ Heart palpitations | ___ Low BP          | ___ Stroke               |
| ___ Diabetes   | ___ Hepatitis          | ___ Metal implants  | ___ Swollen ankles       |
| ___ Dizziness  | ___ Hernia             | ___ Osteoarthritis  | ___ Other (List below)   |
| ___ Fainting   | ___ High BP            | ___ Osteoporosis    | _____                    |

**List any surgeries with dates:**

\_\_\_\_\_  
\_\_\_\_\_

What was your exercise program prior to your injury? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What are your goals? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How did you hear about Sutton Place Physical Therapy? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you visited our website?    Yes             No   
www.suttonplacept.com