Stillwater Medical Blackwell

PT Intake Assessment
580.363.9375

The information you provide is very important to your health and will help orient our staff to your goals. Please take time to fully and completely fill out this form. **NOTE: If you are currently receiving any type of home health care services, please see the receptionist before completing this form.**

Date:	**Date Symptoms Began:**	
Preferred Communication method (please circle): Call text email		**Appt Reminders:Y / N**
Email:	**Phone:**	

PLEASE ANSWER THE FOLLOWING QUESTIONS COMPLETELY

1. Reason for being referred to physical therapy or speech therapy:_____

2. Check all that apply and explain the following medical problems that you have had:

☐ AIDS/HIV	☐ COVID-19	☐ Heart Murmur/Defect	☐ Pacemaker
☐ Anemia	☐ Dementia	☐ Hepatitis	☐ Psychiatric Treatment
☐ Asthma	☐ Depression	☐ Herpes	☐ Rhuematoid Arthritis
☐ Back Trouble	☐ Diabetes	☐ High Blood Pressure	☐ Seizures
☐ Cancer	☐ Emphysema	☐ Kidney Disease	☐ Stroke
☐ Chest Pain	☐ Fainting	☐ Liver Disease	☐ Substance Abuse
☐ Congestive Heart Failure	☐ Fractures	☐ Motor Vehicle Accident	☐ Thyroid Disease
☐ COPD	☐ Glaucoma	☐ Osteoarthritis	☐ Ulcer
	☐ Heart Attack/Disease		

Explain as Necessary:_____

_____

3. List any surgeries that you have had:

_____
_____
_____
_____
_____

4. List all medications you are currently taking: (if you have a list we can copy for you)

_____
_____
_____
_____
_____

5. List any allergies or drug reactions:_____

6. Are these symptoms are result of an injury or accident? No. If Yes, describe what happened:

_____

What special test(s) have you had for this condition? (check all that apply)

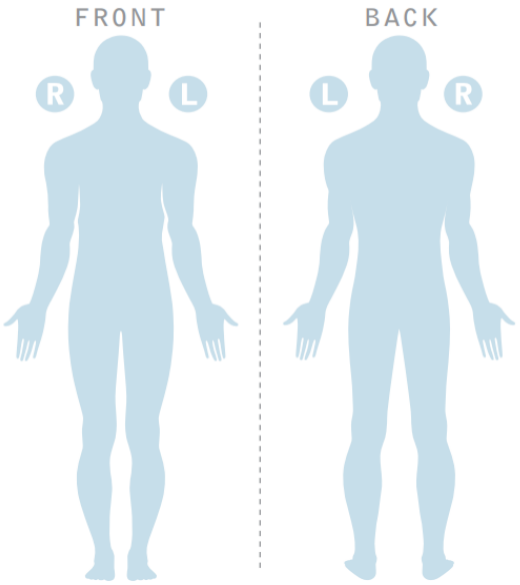
☐ Cat Scan	☐ Injection	☐ Bone Scan	☐ MRI	☐ X-ray	☐ Other:_____
Date:	Date:	Date:	Date:	Date:	Date:

Have you sought other treatment for this condition?

_____

PAIN INDICATOR

KEY
X = Sharp Sensation
O = Numbness or Tingling
 # = Dull Aching
+ = Burning Sensation
> = Radiating Pain



Current Pain	Worst Pain	Best Pain	Acceptable Pain

1 2 3 4 5 6 7 8 9 10
No Pain — Mild — Moderate — Severe — Worst Possible

What Do You Expect to Gain/Accomplish from Participation in Therapy?

_____

Do you exercise outside of normal daily activity? ☐ No ☐ Occasionally ☐ 1-3/ wk ☐ 4+

Occupation:_____

Physical Activities at work (if no longer working your normal activity at home)
☐ sitting ☐ standing ☐ phone use
☐ repetitive lifting ☐ heavy lifting
☐ computer use ☐ driving ☐ bending
☐ overhead activities ☐ other_____

Smoke: No / Yes, How many cigarettes daily:____

If you are not performing your normal activities at work/home, do you plan to return to your previous activity level? No
Yes, preferably by date:_____

Are you currently seeking disability for this condition? Yes No

Since Onset of Current Symptoms have you had the following : ☐ changes in bowel/bladder function
☐ unexplained weight loss ☐ night pain/sweats
☐ vision/hearing change

Please tell us how you learned of our services:
☐ Former Patient ☐ Friend/Family ☐ Doctor ☐ radio ☐ newspaper ☐ phone book ☐ internet ☐ Other:_____

Thank you for choosing Stillwater Medical-Perry Rehab Services, where our goal is to provide you with an exceptional experience. We look forward to assisting you in meeting your therapy goals.

Patient Signature: _____ Date: _____