Total Health

OFFERED BY STILLWATER MEDICAL CENTER

Intake Assessment
405.624.6592
DATE: ____ /____ /_______

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

GENERAL INFORMATION:

NAME:			DATE OF BIRTH:
HOME #:	CELL #:	WORK #:	EMERGENCY CONTACT#:
EMAIL ADDRESS:		ONSET DATE OF SYMPTOMS:	
REFERRING PHYSICIAN:		PRIMARY CARE PHYSICIAN:	

PLEASE ANSWER THE FOLLOWING QUESTIONS COMPLETELY

1. Reason for being referred to physical therapy / occupational therapy:

____

____

____

2. What do you expect to accomplish by attending therapy?

____

____

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

- ☐ AIDS/HIV
- ☐ Allergies
- ☐ Anemia
- ☐ Anxiety/Depression
- ☐ Asthma
- ☐ Back Trouble
- ☐ Cancer
- ☐ Chest Pain
- ☐ COPD
- ☐ Dementia
- ☐ Diabetes
- ☐ Emphysema
- ☐ Fractures
- ☐ Heart Condition
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Motor Vehicle Accident
- ☐ Neuropathy
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Post-Polio Syndrome
- ☐ Psychiatric Treatment
- ☐ Rheumatoid Arthritis
- ☐ Seizures
- ☐ Shortness of Breath
- ☐ Sinusitis
- ☐ Stroke
- ☐ Swelling Hands/Feet
- ☐ Thyroid Disease
- ☐ Tuberculosis

Explain as necessary:

____

____

4. List any operation or surgeries that you have had:

____

____

5. List any medications you are currently taking:

____

____

6. List any allergies and describe any drug reactions: ______________________________

Are you allergic to latex? ☐ Yes ☐ No ______________________________

7. Please check any of the following you may have/wear:

☐ Glasses ☐ Contacts ☐ Dentures ☐ Pacemaker ☐ Metal/Foreign Object Implant ☐ Hearing Aides

8. Are you pregnant? ☐ Yes ☐ No

9. Any significant weight gain/loss in the last year? ☐ Yes ☐ No If yes, (+, -)______lbs.

CURRENT MEDICAL CONDITION

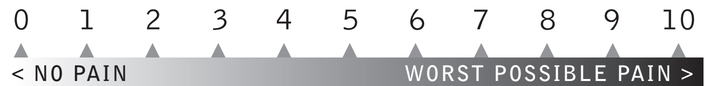
If you indicated pain above, use the key below to indicate on the chart(s) the appropriate symptom(s) and area(s) where you are having the most pain.

PAIN INDICATOR

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

FRONT R L
BACK L R

Worst Pain Level:______ Current Pain Level: _________
Best Pain Level: ________ Acceptable Pain Level: ______



What makes symptoms better?

What makes symptoms worse?

How have the symptoms changed since onset: ☐ Better ☐ Worse ☐ No change

What special test have you had for this condition? (Mark below all that you've had and the dates completed)

☐ Cat Scan	☐ Injection	☐ Bone Scan	☐ Discogram	☐ EMG	☐ MRI	☐ X-ray
DATE:	DATE:	DATE:	DATE:	DATE:	DATE:	DATE:

Have you had therapy for this condition before? ☐ Yes ☐ No If yes, when and where?

Patient-specific activity scoring scheme

The information below is critical to obtain for insurance payment.

Please identify **at least three important activities** that you are unable to do or are **having difficulty with** as a result of your current problem/diagnosis (i.e. the reason your doctor has referred you to therapy). Today, are there any activities that you are unable to do or having difficulty with because of your problem/diagnosis?

Rate each of these problems on the 0-10 scale:
0 = Unable to perform activity (Cannot perform)
10 = Able to perform activity at the same level as before injury or problem (No Issues)

1. Activity:
0 1 2 3 4 5 6 7 8 9 10
CANNOT PERFORM NO ISSUES

2. Activity:
0 1 2 3 4 5 6 7 8 9 10
CANNOT PERFORM NO ISSUES

3. Activity:
0 1 2 3 4 5 6 7 8 9 10
CANNOT PERFORM NO ISSUES

4. Activity:
0 1 2 3 4 5 6 7 8 9 10
CANNOT PERFORM NO ISSUES

To the best of my belief, this information is true and correct.

PATIENT SIGNATURE

THERAPIST SIGNATURE