

# 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:

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

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

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

Explain as necessary:

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

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5. List any medications you are currently taking:

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6. List any allergies and describe any drug reactions: \_\_\_\_\_

Are you allergic to latex?  Yes  No

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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**

**O = Numbness or Tingling**

**# = Dull Aching**

**+ = Burning Sensation**

**> = Radiating Pain**

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)

<input type="checkbox"/> Cat Scan	<input type="checkbox"/> Injection	<input type="checkbox"/> Bone Scan	<input type="checkbox"/> Discogram	<input type="checkbox"/> EMG	<input type="checkbox"/> MRI	<input type="checkbox"/> 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