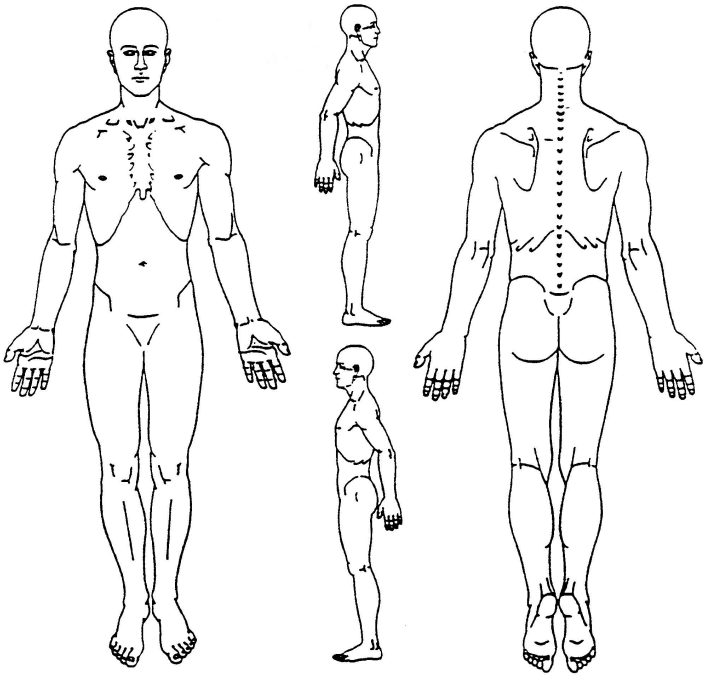
ROGUE
PHYSICAL THERAPY

NEW PATIENT INTAKE FORM

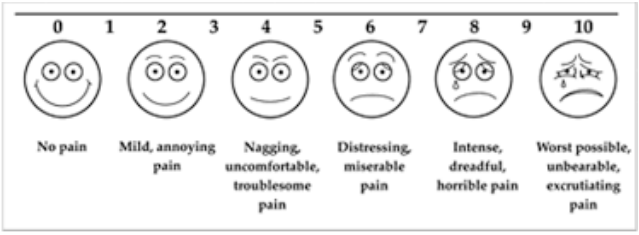
Name_____ Date_____ Birthdate_____ Age_____

Height_____'_____" Weight_____ Referring Physician_____

Where is your pain? Locate injury site/region.



Please indicate current severity of pain, and highest experienced.



Describe your pain (ie. Dull/Sharp, Deep/Shallow, Achy, tingling, numbness)_____

_____

Frequency of symptoms (circle best response)

1. Constant (always there 24hrs/day)
2. Intermittent (symptoms fluctuate throughout day)

What percent of the day do you notice your symptoms?

Circle one: 25% 50% 75% 100%

When is the pain at its worst? _____

Is there pain present at night? Y N

What position helps you sleep? _____

When did you first notice pain/dysfunction? Briefly describe onset. _____

_____

_____

_____

_____

What makes it feel worse? _____

_____

How long will a typical flare up last? _____

What makes it feel better? _____

_____

How long is relief provided?_____

Have you had surgery for this condition? Y N

If yes, approximate date _____

Have you had injections for this condition? Y N

If yes, approximate date _____

List any diagnostic tests you had had for this condition:

_____

When are you scheduled to see your doctor again?

_____

Have you been to another medical professional? If so, what helped, what didn't? _____

_____

Goals for Physical Therapy _____

_____

Medical History (check all that apply)

____ Heart Disease _____Diabetes _____ High Blood Pressure _____ Pacemaker _____ Cancer ____ Stroke

____ Tuberculosis _____HIV/AIDS _____Visual Impaired _____ Hepatitis _____ Asthma _____ Arthritis

____ Osteoporosis _____ Seizures _____ Hearing Impaired _____ Scoliosis _____ Kidney Problems

_____Latex allergy _____ Pregnant _____ Fractures _____ Dizziness _____ Metal Implants

Other:

_____

Do you smoke? Y N

Please list your medications:
