Oregon Physical Therapy at TImberhill

Health Intake Form

Name: _____ Date: ____/____/_____

Weight: _____ Height: _____

On the scale below, please mark the number which best represents the severity of your pain over the past 24 hours:

0 1 2 3 4 5 6 7 8 9 10

No Pain Worst Pain Imaginable

Since your symptoms began, have you noticed any of the following? (Check all that apply)

- ☐ Fatigue
- ☐ Generalized muscle weakness
- ☐ Pain at night
- ☐ Leg swelling
- ☐ Weight Loss/Gain
- ☐ Difficulty maintaining balance when walking
- ☐ Changes in bowel or bladder function
- ☐ Changes in cognition
- ☐ Falls in the last year #___
- ☐ Numbness or tingling
- ☐ Shortness of breath
- ☐ Heartburn/Indigestion
- ☐ Difficulty swallowing
- ☐ Headaches
- ☐ Changes in appetite
- ☐ Heart palpitations
- ☐ Fever/Chills/Sweats
- ☐ Nausea/Vomiting
- ☐ Abdominal pain
- ☐ Dizziness/ Imbalance
- ☐ Cough
- ☐ Chest pain especially with sweats
- ☐ Skin changes
- ☐ Other: _____

Medical History: Have you ever been diagnosed with or do you have any of the following conditions? (Check all that apply)

- ☐ Cancer
- ☐ Heart problems
- ☐ Chest pain/ Angina
- ☐ Circulation Problems
- ☐ Blood clots
- ☐ Stroke
- ☐ Anemia
- ☐ Chemical dependency: i.e. (Alcoholism)
- ☐ Depression
- ☐ Anxiety
- ☐ Lung problems
- ☐ Tuberculosis
- ☐ Sexually transmitted disease/HIV
- ☐ Rheumatoid arthritis
- ☐ Arthritis
- ☐ Bladder/Urinary tract infection
- ☐ Kidney problems/Infection
- ☐ Cholesterol High/Low
- ☐ Thyroid problems High/ Low
- ☐ Diabetes
- ☐ Osteoporosis
- ☐ Multiple Sclerosis
- ☐ Epilepsy
- ☐ Ulcers
- ☐ Liver problems
- ☐ Allergies/Asthma
- ☐ Pacemaker
- ☐ Blood thinners
- ☐ Fibromyalgia
- ☐ Broken bones
- ☐ Hepatitis
- ☐ Recent infection/Illness(Explain)
- ☐ Other: _____

Past surgical history (List and Date):

_____

_____

Current Symptoms:

Problem(s) you are here for: _____

What date (roughly) did your symptoms start? _____

What do you think started your symptoms? _____

Are your symptoms related to a work injury? ☐ Yes ☐ No Or a motor vehicular accident? ☐ Yes ☐ No

Symptoms are currently: ☐ Getting better ☐ Getting worse ☐ Staying about the same

☐ Come and go ☐ Constant ☐ Constant, but change with activity

Treatments so far for this problem (Injections, Chiropractic, etc.): _____

Have you had X-ray, MRI, or other imaging done for this problem? ☐ Yes ☐ No

If yes, please list, including the date: _____

Have you ever had this problem before? ☐ Yes ☐ No

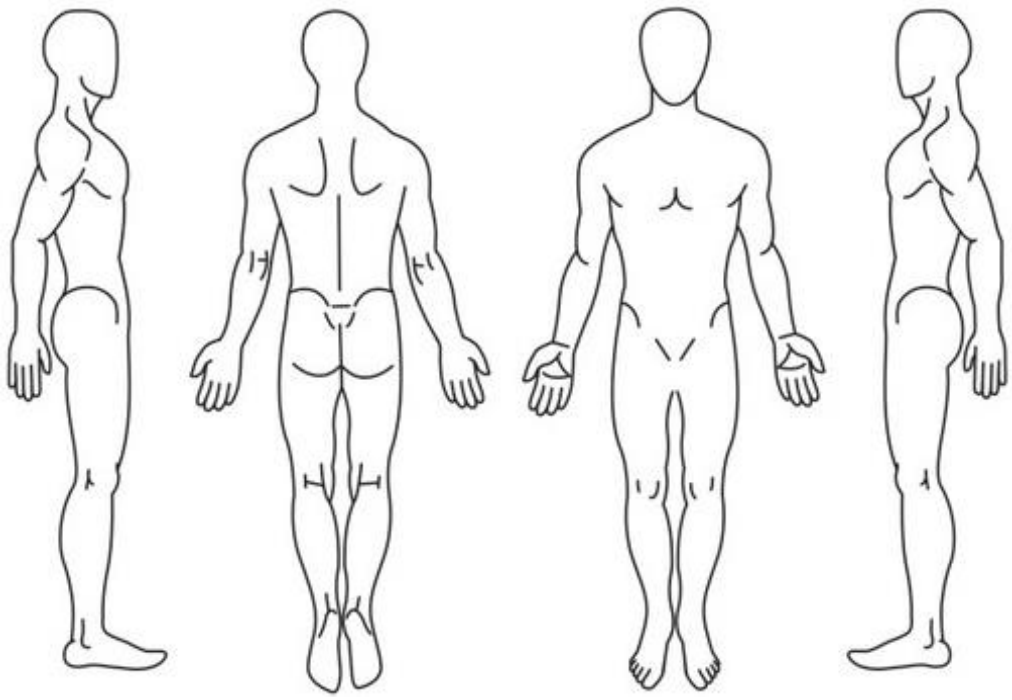
If yes, when and how was it treated?

_____

What is your personal goal for therapy? _____

Body Chart:

***Please mark **ALL** areas where you feel symptoms on the chart*



What makes your symptoms better? _____

What makes your symptoms worse? _____

Are you able to sleep at night?

☐ Fine ☐ Moderate difficultly

☐ Only with medication