

Patient Intake

Name:		Male / Female	Age:		Oate:	
Diagnosis:			Date of Injury:			
Surgery for this condition:				Date of Surgery:		
How did the injury occur?						
Diagnostic Tests: (ch	eck boxes that apply)		CT Scan	□ X-Ray	□ None	
Other						
Test Results:						
Pain:	Mark an "x" on the diagram where your symptoms are.					
	No Pain	3 4 5	6 7		9 10 Worst (Emergency Room)	
	What makes your symptoms better?					
	What makes your symptoms worse?Are your symptoms: □ Constant □ Intermittent □ Getting worse □ Getting better □ Not Changing					
ਪੁੱੱ Medications:	Are your symptoms: □ C Anti-inflammatory			g worse ப Ge le Relaxant		
	•					
Previous Therapies & Treatments:						
	eck all boxes that apply) ☐ Heart Disease	□ No Significant I□ Heart Attack		y Blood Pressure	☐ Stroke	
☐ Seizures	□ Arthritis □ Diabetes □ Allerg		/			
☐ Surgeries: _						
☐ Other:						
Are you presently working? Yes No Off work since Occupation						
Circle the activities tha	t best apply to your function	onal limitations.				
Sitting	Stairclimbing		ing Dressed		Gripping	
Standing	Driving	•	rts/hobbies		eeding	
Squatting Walking	Lifting/Carrying Housework/Yardv		oming		eaching eeping	
	Tiousework raid	Work Bail	9		леерінд	
2						
This information was reviewed with the patient.						
Patient Signature:				Date:	Time:	
Thoronist Signature				Dato	Time	

