

Stillwater Medical Center TOTAL HEALTH
Intake Assessment
405-624-6592

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. Your individual background, cultural and family surroundings are important factors in your response to illness and treatment. Please take time to fully and completely fill out this very important information. We are counting on you.

Date: _____

Note: If you are currently receiving any type of Home Health Care service, please see the receptionist before completing this form.

General Information

Patient's Name: _____ Date of Birth: _____

Referring Physician's Name: _____ Other Referral Source: _____

Home Phone: _____ BusinessPhone: _____ Pager: _____ Cell: _____

Return to Dr. Date: _____ Primary Care Physician: _____

Medical History

Hypertension Diabetes Seizures Cancer Muscle/Joint

Cardiac Condition: Describe _____

Hospitalizations/Surgeries including approximate dates *for this injury/condition or would be related to treatment for this injury/condition*: _____

Please list all other health problems? _____

Current medications: _____

Are you ALLERGIC to any drugs? Yes ___ No ___ If yes, what drugs? _____

Are you allergic to Latex? _____

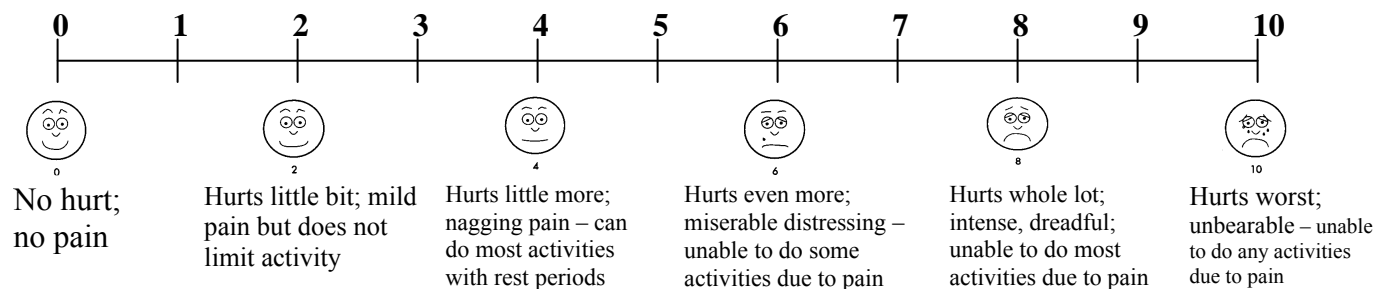
Do you use any special equipment for daily activities, such as a hearing aide, glasses, cane? _____

Do you have any balance difficulties or a history of falls Yes__No__

Current Medical Condition

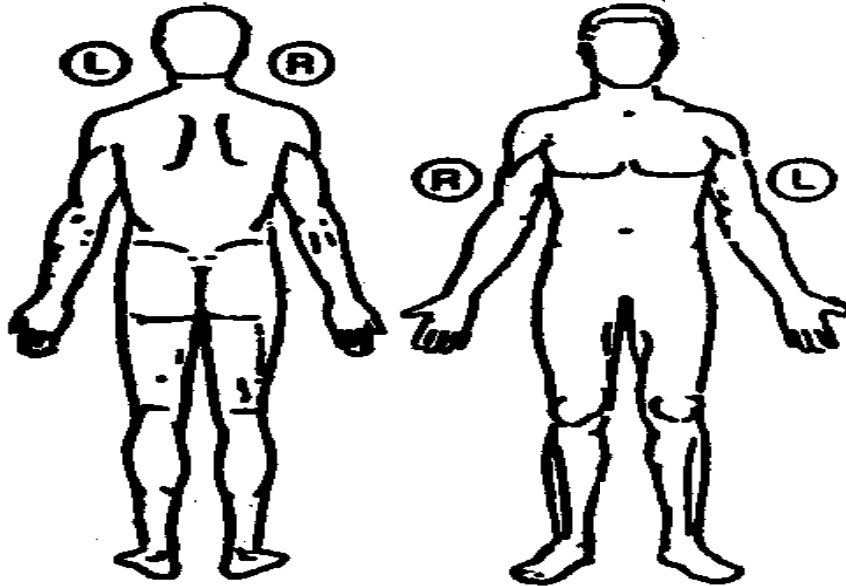
Using the numerical scale below, indicate your present level of pain _____, the worst your pain gets _____, and the best your pain gets _____. If you do have pain, do you take anything for it? _____

What is your Acceptable pain level? _____



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.

- | | | |
|-------------|---|-----------------------------|
| X | = | Sharp Sensations |
| O | = | Numbness or Tingling |
| # | = | Dull Aching |
| + | = | Burning Sensations |
| > | = | Radiating |



When did these symptoms first occur? (Approximate a date, if necessary) _____

If these symptoms are the result of an injury/accident, describe what happened: _____

How have the symptoms changed since the onset? _____

What makes the symptoms better? _____

What makes the symptoms worse? _____

What special tests have you had for this condition? _____

CAT Scan ___ Injections ___ Bone Scan ___ Discogram ___ EMG ___ MRI ___ X-Ray ___

Have you ever had therapy for this condition? Yes ___ No ___ If yes, when and where? _____

Occupational-Social

Are you currently employed? Yes ___ No ___ If yes, where? _____

What type of work do you do? _____

Have you missed any work because of this condition? ___ If yes, how much? _____

Are you able to work now? Yes ___ No ___ If RETIRED, as of what date? _____

Do you have any special needs for: Vision Hearing Speech Other

What are your learning preferences? Seeing Verbal Explanation Written Instructions

Do you have religious/cultural practices which may impact your therapy? Yes No

How have the current symptoms interfered with any work related, sports, and/or recreational activities? _____

Describe your current support system at home for your treatment: _____

Note: often we find our patients are dealing with being threatened or hurt physically, emotionally, and/or sexually by someone close to them. If this is happening in your life, please talk to your therapist.

Patient/Family Concerns and Goals

Please describe your major concerns and/or goals with seeking treatment. List them in order of importance to you.

1. _____
2. _____
3. _____

Appointments

If a patient is 15 minutes late, or more, to an appointment, their appointment can be cancelled.

Please notify us as soon as possible if you know you will be unable to keep your appointment. If a patient CANCELS more than 2 appointments in a row, patient will be notified and future appointments will be discussed. If a patient NO SHOWS for 2 appointments, all future appointments will be cancelled.

The above is true and correct to the best of my belief

Patient Signature: _____ *Date:* _____

.....
Therapist to write below this line.
.....

Therapist Signature: _____ *Date:* _____