Total Health

OFFERED BY STILLWATER MEDICAL CENTER

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. 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.**

DATE: ____ /____ /_____

GENERAL INFORMATION:

NAME:			DATE OF BIRTH:
HOME #:	CELL #:	WORK #:	OTHER CONTACT#:
REFERRING PHYSICIAN:		PRIMARY CARE PHYSICIAN:	
RETURN TO DOCTOR DATE:		ONSET DATE OF SYMPTOMS:	

PLEASE ANSWER THE FOLLOWING QUESTIONS COMPLETELY

1. Reason for being referred to physical therapy / occupational therapy:

_____

_____

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

☐ AIDS/HIV	☐ Congenital Heart Defect	☐ Fainting	☐ High Blood Pressure	☐ Shortness of Breath
☐ Allergies	☐ Congestive Heart Failure	☐ Fractures	☐ Jaundice	☐ Sinusitis
☐ Anemia	☐ Convulsions	☐ Glaucoma	☐ Kidney Disease	☐ Stomach Ulcers
☐ Asthma	☐ COPD	☐ Heart Disease	☐ Liver Disease	☐ Stroke
☐ Back Trouble	☐ Dementia	☐ Heart Attack	☐ Motor Vehicle Accident	☐ Swelling Hands/Feet
☐ Bronchitis	☐ Diabetes	☐ Heart Murmur	☐ Psychiatric Treatment	☐ Thyroid Disease
☐ Cancer	☐ Drug Abuse	☐ Hepatitis	☐ Rheumatic Heart Disease	☐ Tuberculosis
☐ Chest Pain	☐ Emphysema	☐ Herpes	☐ Seizures	☐ Rheumatic Fever

Explain as necessary:

_____

_____

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

_____

_____

4. List any medications you are currently taking:

_____

_____

5. List any allergies and describe any drug reactions: _____
Are you allergic to latex? ☐ Yes ☐ No _____

6. Please check any of the following you may have/wear:

☐ Glasses ☐ Contacts ☐ Dentures ☐ Pacemaker ☐ Metal/Foreign Object Implant ☐ Hearing Aides

7. Are you pregnant? ☐ Yes ☐ No

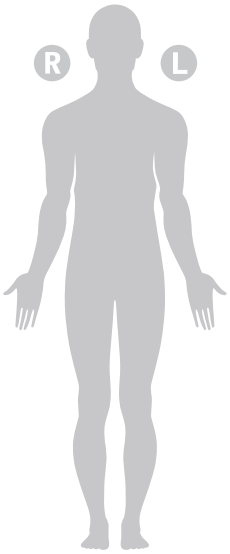
8. Any significant weight gain/loss in the last year? ☐ Yes ☐ No If yes, (+, -)_____lbs.

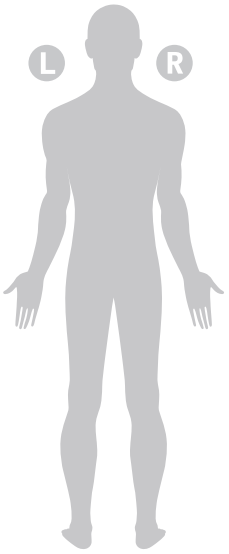
CURRENT MEDICAL CONDITION

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





If these symptoms are result of an injury or accident, describe what happened:

_____

_____

How have the symptoms changed since onset? ☐ Better ☐ Worse ☐ No change

_____

What makes symptoms better?

_____

_____

_____

What makes symptoms worse?

_____

_____

_____

What special test have you had for this condition? (Mark below all that you've had and the dates completed)

☐ Cat Scan	☐ Injection	☐ Bone Scan	☐ Discogram	☐ EMG	☐ MRI	☐ X-ray
DATE:	DATE:	DATE:	DATE:	DATE:	DATE:	DATE:

Have you had therapy for this condition before? ☐ Yes ☐ No If yes, when and where?

_____

_____

CURRENT PAIN LEVEL	WORST PAIN LEVEL	BEST PAIN LEVEL	ACCEPTABLE PAIN LEVEL

0 1 2 3 4 5 6 7 8 9 10

< NO PAIN WORST POSSIBLE PAIN >

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

_____

What do you expect to gain/accomplish in receiving therapy? _____

_____

To the best of my belief, this information is true and correct.

_____ _____

PATIENT SIGNATURE THERAPIST SIGNATURE

1/2013