Southwest General
Partnering with University Hospitals

Patient Intake

Patient Label

Name:_____ Male / Female Age:_____ Date of Birth:_____

Diagnosis:_____ Date of Injury:_____

Surgery for this condition:_____ Date of Surgery:_____

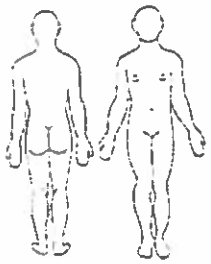
How did the injury occur?_____

_____

Diagnostic Tests: (check boxes that apply) ☐ MRI ☐ CT Scan ☐ X-Ray ☐ None ☐ Other

Test Results:_____

Pain: Mark an "x" on the diagram where your symptoms are.



Rate your average and worst pain. (circle the number)

0 1 2 3 4 5 6 7 8 9 10

No Pain Worst (Emergency Room)

What makes your symptoms better?_____

What makes your symptoms worse?_____

Are your symptoms: ☐ Constant ☐ Intermittent ☐ Getting worse ☐ Getting better ☐ Not Changing

Medications: ☐ Anti-inflammatory ☐ Pain Killer ☐ Muscle Relaxant ☐ None

☐ _____

Previous Therapies & Treatments:_____

Fall in the past year? ☐ Yes ☐ No if yes, # ____ If injury sustained? ☐ Yes ☐ No *if yes describe:* _____

Medical History: *(check all boxes that apply)* ☐ No Significant Medical History

☐ Change in bowel / bladder function	☐ DVT	☐ Smoker	☐ Incontinence
☐ Unexplained weight loss / gain	☐ Pacemaker	☐ Osteoporsis	
☐ Depression	☐ Currently pregnant	☐ Cancer	
☐ Heart Disease / Heart Attack	☐ High Blood Pressure	☐ Stroke	
☐ Seizures	☐ Arthritis	☐ Diabetes	

☐ Allergy _____

☐ Surgeries: _____

☐ Other: _____

Are you presently working? ☐ **Yes** ☐ **No** **Off work since**_____ **Occupation**_____

Circle the activities that best apply to your functional limitations.

☐ Sitting	☐ Standing	☐ Squatting	☐ Walking	☐ Stairclimbing	☐ Driving
☐ Lifting/Carrying	☐ Housework/Yardwork	☐ Getting Dressed		☐ Sports/hobbies	☐ Grooming
☐ Bathing	☐ Gripping	☐ Feeding	☐ Reaching	☐ Sleeping	

List your goals:

1. _____
2. _____
3. _____

Patient Signature:_____ **Date:**_____ **Time:** _____