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:**_____

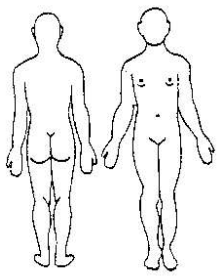
**How did the injury occur?**_____

_____

**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:** _____