TUALITY HEALTHCARE
An OHSU Partner

Rehabilitation Services
INTAKE FORM

Date: _____

What are you being seen for today? _____

When did this problem begin? _____

What makes your symptoms worse? _____

What makes your symptoms better? _____

Have you undergone any special tests for this problem (X-ray, MRI, etc)? If so, please list with results:

_____

What would you like to achieve with therapy? _____

Occupation: _____

Outside Interests/activities, sports, hobbies: _____

PAIN ASSESSMENT

Rating	Description
9 10	Immediate emergency, hospitalization, unable to speak, incapacitated, worst pain imaginable
7 8	Tearful, needing to lie down, needing to take extra medications, difficulty engaging in conversation
5 6	Needing to stop the activity you are currently performing, unable to maintain body position, very restricted movement
3 4	Require more breaks, slowed work rate, slowed or altered movements, lean on nearby surfaces, limp
1 2	Pain is there but is low in intensity and is manageable, no observed limitations due to pain
0	No pain, no limitations due to pain

Using the above scale, please rate your pain between 0-10:

Today: _____

Over the past few weeks:

Best: _____

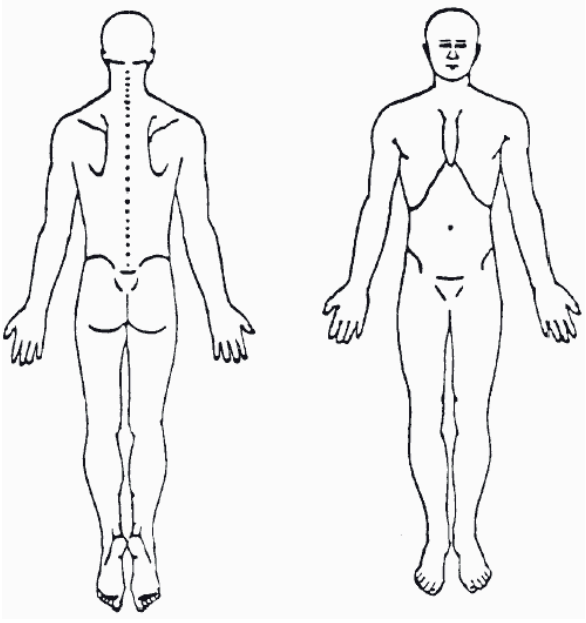
Worst: _____

Please circle the word(s) below that best describe your symptoms:

aching, burning, cramping, dull, heavy, numbness, pressure, radiating, sharp, tightness, tingling

other: _____

Please mark the area of symptoms on the body diagram below:



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MEDICAL HISTORY

Date: _____

Do you have, or have you had any of the following conditions?

- ☐ Arthritis / Osteoporosis (Where:_____)
- ☐ Blood clots
- ☐ Blood disease: _____
- ☐ Cancer (Type: _____)
- ☐ Diabetes: Pills / Insulin / Diet controlled
- ☐ Drug-resistant infection / MRSA
- ☐ Epilepsy / Seizures
- ☐ Fibromyalgia
- ☐ Head injury (Date: _____)
- ☐ Heart condition: _____
- ☐ Hernia
- ☐ High blood pressure
- ☐ Immune disorder: _____
- ☐ Kidney disease / Dialysis
- ☐ Liver disease / Hepatitis
- ☐ Lung disease: _____
- ☐ Lymphedema (Where:_____)
- ☐ Multiple Sclerosis
- ☐ Spinal cord injury (Date: _____)
- ☐ Stroke / TIA (Date: _____)
- ☐ Thyroid disorder: Hypo / Hyper
- ☐ Hearing problem _____
- ☐ Memory problem _____
- ☐ Speech / swallowing problem
- ☐ Vision problem _____

- Are you pregnant / nursing? (circle if yes)
- Do you smoke? YES / NO Packs/day:_____
- Do you have a history of falls? YES / NO Date of last fall: _____
  How & where did you fall? _____

Please list any other medical history that we should be aware of:

_____ Date: _____ _____ Date: _____
_____ Date: _____ _____ Date: _____

Please list any surgeries that we should be aware of:

_____ Date: _____ _____ Date: _____
_____ Date: _____ _____ Date: _____

Please list current medications with dosages: ☐ No current medications

_____
_____

Please list any allergies to medications, adhesives, or latex: ☐ No known allergies

_____

Have you received any other therapy services this year? (Include nursing home, home health, etc.)

☐ Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy Where: _____