Pontchartrain
ORTHOPEDICS & SPORTS MEDICINE

Physical Therapy Intake Form

Name:____ **Date:** ______________________

Phone Number: ________________ **Age:** ____________ **Height/Weight:** _____________

Leisure Activities (including exercise routines): ____

Occupation (including activities that compromise your work day): ________________________

Please initial the following for understanding and agreement.
Parent and/or legal guardian must initial if patient is a minor.

CONSENT TO TREAT:

_______ I understand that my diagnosis and treatment plan will be discussed during my appointment and that I have the right to question and/or refuse any treatment offered.

NO SHOW POLICY:

_______ Missing 3 consecutive PT appointments without calling to cancel at least 2 hours prior to scheduled appointment time may result in discontinuation of your future PT appointments. You must then return to your referring physician for another referral to resume care.

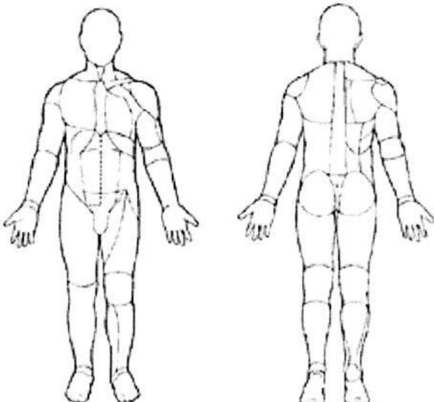
_______ If you are more than 15 minutes late for your appointment you will be considered a No Show and asked to reschedule.

CHAPERONES:

_______ I understand that I have the right to request a chaperone prior to or at any time during my evaluation/treatment.

FRAGRANCE FREE POLICY:

_______ Some individuals may be sensitive to, or exeperience negative effects from certain fragrances or chemicals present in colognes, perfumes, scented lotions or aftershave, powders, and similar products. As a result, we ask that you not wear any of the products mentioned above during your visit.



CURRENT COMPLAINT

***Using the body chart to the LEFT*, please mark the area(s) for your current complaint with the following symbols:**

/// Numbness = Tingling ◊ Dull ache ↓ Shooting/Sharp

When (approximately) did your CURRENT symptoms/complaint start?

____

What do you think caused your CURRENT symptoms/problems?

□ Work related injury □ Motor vehicle accident

□ Recurrence of previous injury □ Athletic/Recreational injury

□ Other: ____

Special testing/imaging completed for your CURRENT symptoms/problem:

□ X-Ray □ MRI □ Bone Scan □ Ultrasound □ Labs □ None

Treatment received so far for THIS symptom/problem:

□ Injection □ Epidural □ Medication □ Surgery □ Physical Therapy
□ Chiropractic □ None

Regarding your CURRENT symptoms/problem, how are you sleeping at night? Circle all that apply.

No problems sleeping Difficulty falling asleep Awakened by pain Sleep only with medication

When are your symptoms the BEST? Circle all that apply.

Morning Afternoon Evening Night After exercise

When are your symptoms the WORST? Circle all that apply.

Morning Afternoon Evening Night After exercise

My symptoms currently:

□ Come and go □ Are constant □ Are constant, but vary with activity
□ Are getting better □ Are getting worse □ Are staying about the same

Identify up to 4 positions or activities that make your symptoms WORSE:

1. ________________ **2.** ________________ **3.** ________________ **4.** ________________

Identify up to 4 positions or activities that make your symptoms BETTER:

1. ________________ **2.** ________________ **3.** ________________ **4.** ________________

On the pain scale below, circle the number that best represents your CURRENT level of pain:

0	1	**2**	3	**4**	5	**6**	7	**8**	9	**10**
No pain		**Mild** Can be ignored		**Moderate** Interferes with tasks		**Moderate** Interferes with concentration		**Severe** Interferes with basic needs		**Worst Pain Imaginable** Emergency

Using the numeric scale above, rate: **The BEST your pain has been in the last 24 hours:** ______
The WORST your pain has been in the past 24 hours: ______

What is your goal for physical therapy at this time, or what do you wish to achieve by attending physical therapy? ________________________________

Latex Allergy? Yes No **Pacemaker?** Yes No **Difficulty hearing or seeing?** Yes No

Is there anything else you would like us to know or feel we should be aware of while treating you in our clinic?

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