GIRARD ORTHOPAEDICS PHYSICAL THERAPY & HAND CENTER PATIENT INTAKE FORM

Name_____ Age_____ Phone _____

Current Address: _____E-mail: _____

Emergency contact name and phone #: _____

Primary Physician_____Date of Injury/Impairment_____

Brief Description Of Injury or Impairment_____

_____

What Is Your Chief Complaint?_____

Have You Received Therapy or Other treatment for this condition?_____

My condition is Getting Worse / Getting Better / About The Same (Circle one) **since it began.**

Circle All Those That Best Describe Your Symptoms:

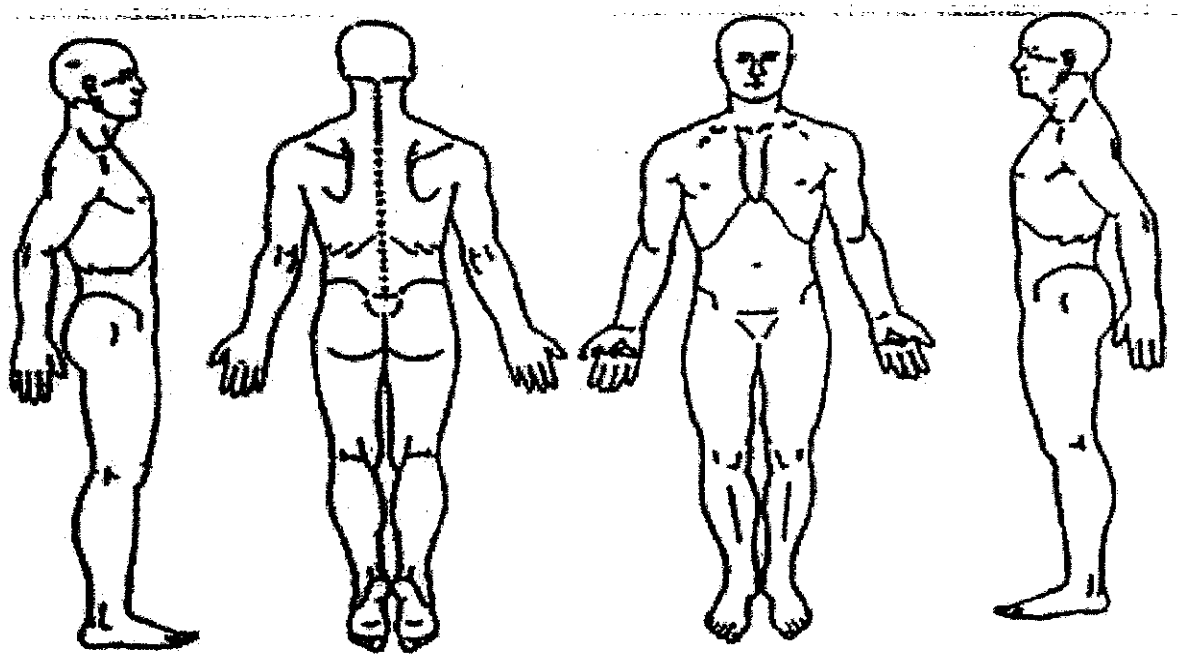
Constant Intermittent Sharp Dull Stabbing Burning Aching Numb Stiff

Circle ONE number that best describes your symptoms (10 being the worst imaginable/0 being pain free):

At Worst:	0	1	2	3	4	5	6	7	8	9	10
At Best:	0	1	2	3	4	5	6	7	8	9	10

Have you had an: X-ray MRI CT Scan **for this Condition?** (Circle)

Please Mark The Body Chart With: P=Pain **N**=Numb/Tingling **W**=Weak **O**=Other (Please Describe Below)



Are You R or L hand Dominant? _____

****TURN PAGE OVER AND COMPLETE****

Circle the activities that are **difficult, painful, or you are unable to perform** due to your condition:

Standing Prolonged standing Sitting Prolonged sitting Walking Lying on your stomach Lying on your back

Walking Sleeping Stairs Stretching Reaching overhead Reaching below waist Turning door knobs Driving

Lifting Grasping Writing Computer use Feeding self Turning key in ignition Opening doors Meal prep

Cutting food Personal hygiene tasks Object Manipulation Tool Use Vacuum/Sweeping/Mopping

Upper body dressing Lower body dressing Bathing Grooming

Other:

What are some treatments or activities that make you feel better? (Ice, Heat, Rest, Certain positions, Medication, Brace, etc)

_____

_____

OCCUPATION_____ **ARE YOU CURRENTLY WORKING?** _____

Is condition affecting your work tasks? Please Explain: _____

Please check if you have been previously diagnosed with or currently apply (leave blank if N/A):

Pacemaker		Vertigo		Diabetes		Anxiety		Fibromyalgia	
Defibrillator		Dizziness		Difficulty Swallowing		Depression		Parkinson's	
Headaches		Osteoarthritis		Cancer		Congestive Heart Failure		Unexplained Weight Loss	
Visual Disturbances		Rheumatoid Arthritis		Difficulty Breathing		Hypertension		Myofascial Pain Syndrome	
Heart Attack		Osteopenia		Stroke / TIA		Seizures		Pregnancy	
Bleeding Problems		(Other)		(Other)		(Other)		(Other)	

Current Medications:_____

Previous Injuries/Surgeries: _____

_____

Have You Had Physical or Occupational Therapy Before? When? For What?_____

_____

What Exercise/Recreational Activities Did You Regularly Participate In Before Your Current Condition?_____

_____

What Are You Hoping To Achieve From Therapy?_____

Patient Signature_____ Date_____

Evaluating Therapist's Signature_____ Date_____