STONE OAK THERAPY SERVICES & LEARNING INSTITUTE

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Physical Therapy Intake Form- Ortho

Patient's Name:			
SSN:	**Sex: (circle one)**	**M F**	**DOB:**
Parent / Legal Guardian Name(s):			
Address:			
Home Phone:	**Work / Alternate Phone:**		**E-mail:**
Emergency Contact:			
Relationship to patient:	**Emergency Contact #:**		
Primary Insurance:	**Policy #:**		
Policy Holder:	**Group #:**		
Policy Holder DOB:	**Policy Holder SSN:**		
Relationship to patient:			
Primary Care / Referring Physician:			
MD phone #:	**MD fax #:**		

Health History

Past Medical History

Please list any injuries, hospitalizations, surgeries or other medical interventions here as well.

Current	Previous	Condition	Explanation
☐	☐	Skin: e.g. rash, topical allergy, eczema	
☐	☐	Muscle: e.g., strain, tendonitis, hyper/hypotonia	
☐	☐	Joints: e.g. arthritis, fractures, contractures	
☐	☐	Nervous system: e.g. stroke, brain injury, shingles	
☐	☐	Respiratory: e.g. chronic lung disorders	
☐	☐	Cardiac / Circulatory: e.g. cardiac defects	
☐	☐	Digestive / GI: e.g. constipation	
☐	☐	Chronic health conditions	

Other special medical concerns / needs: ____

Medications

Name of Medication:	Dosage:	Reason for taking:

Please list any and all drug / food allergies: ____

____

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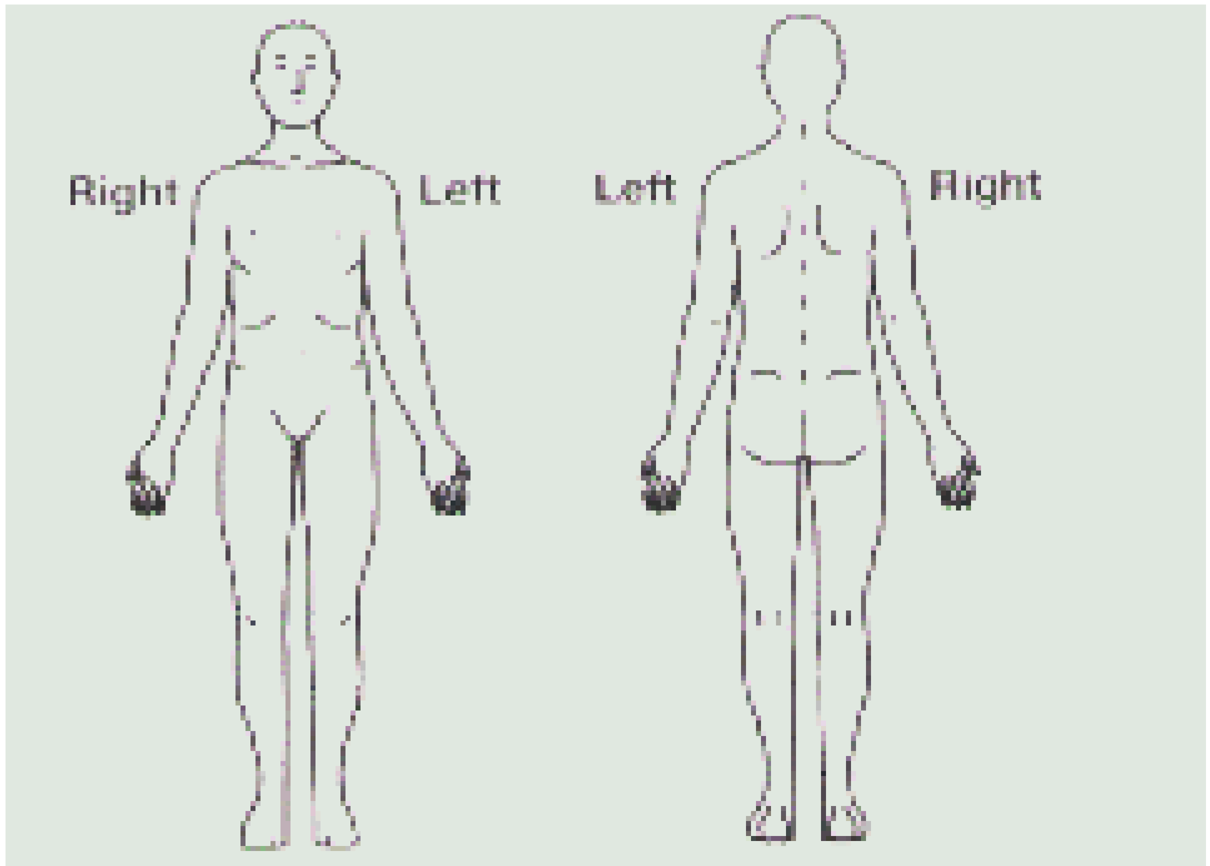
Please mark the following:

X = pain

0 = swelling

~ = tightness



Please describe your chief complaint in your own words: ______________________________________

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On a scale of 1-10, my pain is: ______________ **at worst /** _______________ **at rest /** _____________**with activity**

 Patient's Last Name: _______________ DOB: _______

____ **makes my pain better**

____ **makes my pain worse**

Date of injury: ______________________ **Date of Surgery (if applicable):** ____________________

What happened? ____

Goals

Please check all areas which are goals for you / your child:

- ☐ Increase range of motion (ROM) / flexibility
- ☐ Increase strength
- ☐ Decrease pain
- ☐ Decrease fatigue
- ☐ Improve sports performance
- ☐ Return to prior level of function after injury / surgery
- ☐ Improve gait (walking pattern)
- ☐ Improve balance
- ☐ Improve coordination
- ☐ Improve quality of life

Other goals? ____

____

____

I attest that the aforementioned is complete and accurate to the best of my knowledge.

Patient / Legal Guardian Signature:

____

Patient's Last Name: ______________ DOB: _______