



# STONE OAK THERAPY SERVICES & LEARNING INSTITUTE

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## Physical Therapy Intake Form- Ortho

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

## Health History

### Past Medical History

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

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

Other special medical concerns / needs: \_\_\_\_\_

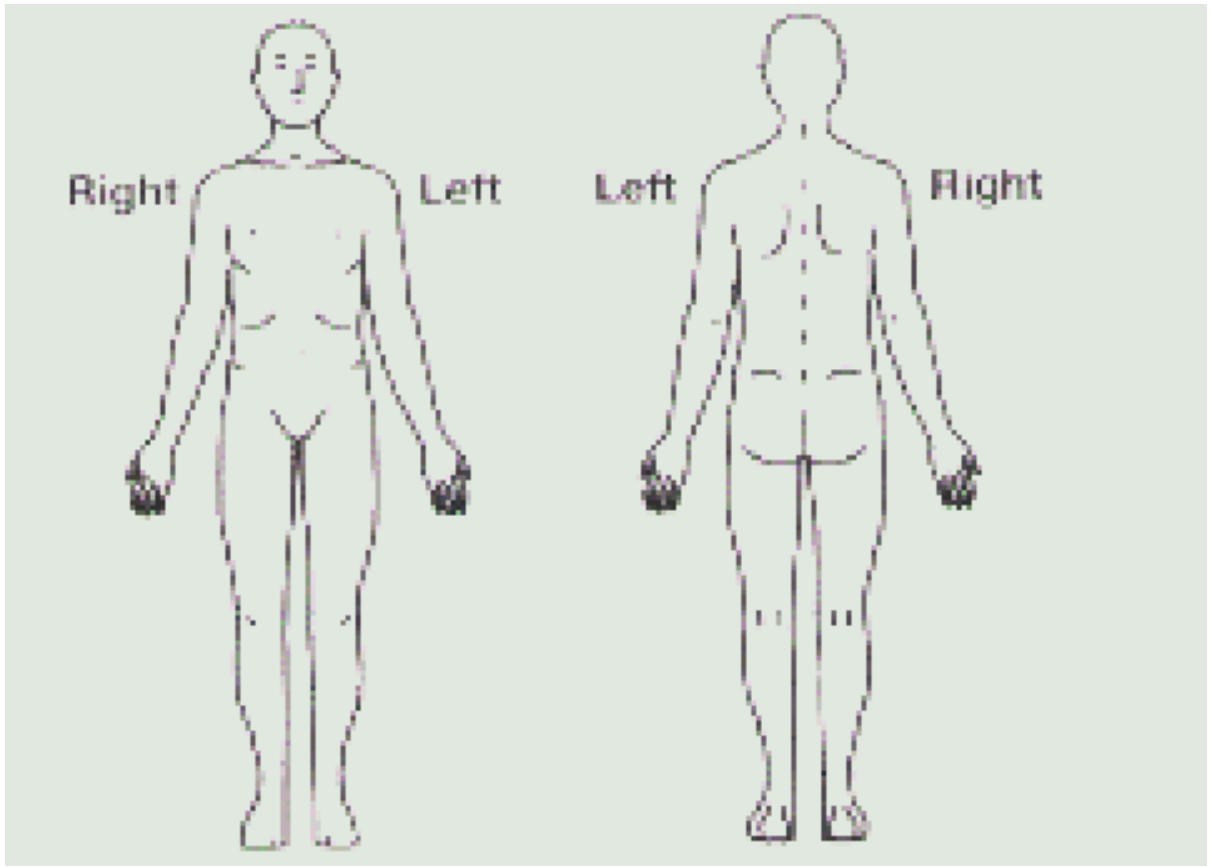
### Medications

Name of Medication:	Dosage:	Reason for taking:


Please list any and all drug / food allergies: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Please mark the following:**

- X = pain**
- 0 = swelling**
- ~ = tightness**



**Please describe your chief complaint in your own words:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**On a scale of 1-10, my pain is:** \_\_\_\_\_ **at worst /** \_\_\_\_\_ **at rest /** \_\_\_\_\_ **with activity**

\_\_\_\_\_ 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:

- |   |   |
|---|---|
| <input type="checkbox"/> Increase range of motion (ROM) / flexibility | <input type="checkbox"/> Return to prior level of function after injury / surgery |
| <input type="checkbox"/> Increase strength                            | <input type="checkbox"/> Improve gait (walking pattern)                           |
| <input type="checkbox"/> Decrease pain                                | <input type="checkbox"/> Improve balance  |
| <input type="checkbox"/> Decrease fatigue                             | <input type="checkbox"/> Improve coordination                                     |
| <input type="checkbox"/> Improve sports performance                   | <input type="checkbox"/> 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:**

\_\_\_\_\_