AFFILIATED HEALTH OF WISCONSIN PHYSICAL THERAPY

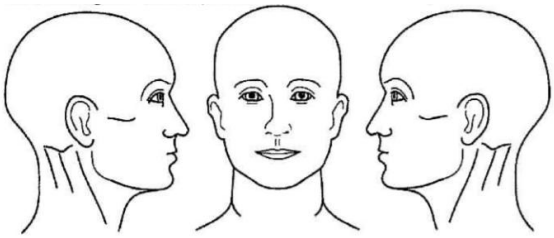
INITIAL INTAKE FORM

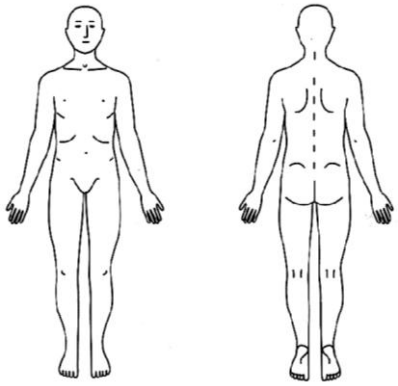
revised 03/10/2018

Name:_____M / F Date of Birth:_____Date:_____

List painful areas and rate pain level:	**No Pain**										**Excruciating Pain**
1._____	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
2._____	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
3._____	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
4._____	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

Please indicate where your pain is by shading the painful areas:





Please circle the words that most closely describe your pain:
Tightness - Ache - Sharp - Shooting - Other: _____
Please check if you have any of the following problems/conditions:

- ☐ Vision Disturbances
- ☐ Light Sensitivity
- ☐ Balance Problems
- ☐ Dizziness
- ☐ Ringing in Ears
- ☐ Arthritis
- ☐ Asthma
- ☐ Diabetes
- ☐ Sleep Apnea
- ☐ Pain with coughing, sneezing or swallowing
- ☐ Pacemaker
- ☐ Loss of control of bowel or bladder
- ☐ Metal Implants e.g. fusion
- ☐ Radiating leg pain
- ☐ Radiating arm pain
- ☐ Sensory changes, e.g. numbness or pins and needles
- ☐ Fibromyalgia
- ☐ Cancer / Tumor
- ☐ Depression / Anxiety
- ☐ Epilepsy / Seizures
- ☐ High Blood Pressure
- ☐ Joint Surgery / Replacement
- ☐ Heart Condition
- ☐ Hepatitis / Liver Disease
- ☐ HIV Positive

1. Date of your injury / initiation of your pain: _____
2. What is the cause of your injury: ☐MVA ☐ Work ☐Sports ☐ Chronic ☐ Unknown
3. Describe your injury briefly: _____
   _____
4. Have you injured this body part(s) before? ☐ Yes, ☐ No, If yes, please explain:
   _____
5. Have you had any of the following tests for this injury(s)? ☐X-Ray ☐MRI ☐CT Scan ☐EMG ☐ Other:
6. Please list your previous surgeries and dates: _____
   _____
7. Are you seeing any other health care providers outside of this facility for this injury? _____
   _____
8. Have you been seen in physical therapy recently? _____
9. Please list other medical problems: _____
   _____Pregnant Y N
10. Please list any medication you are currently taking: _____
    _____
11. Please list any allergies: _____
12. Would you list your job as ☐sedentary ☐light ☐ moderate ☐ heavy
13. Job Title, Job Description: _____
    _____
14. Are you currently working? Yes / No Full / Part time? With / Without Restrictions? On Light Duty?
15. What would you like to accomplish in Physical Therapy? _____

CURRENT FUNCTIONAL LIMITATIONS / ACTIVITIES & PARTICIPATION:

For each of the items below, please indicate the level of limitation during the last month. If the activity has been completely avoided because it is too difficult, then circle '10'. If you avoid an activity for reasons other than pain or difficulty, leave the item blank.

	No limitation										Severe limitation
1. Chew tough food	0	1	2	3	4	5	6	7	8	9	10
2. Chew chicken (e.g. Prepared in oven)	0	1	2	3	4	5	6	7	8	9	10
3. Eat soft food requiring no chewing (e.g. Mashed potatoes, applesauce, pudding, pureed food)	0	1	2	3	4	5	6	7	8	9	10
4. Open wide enough to drink from a cup	0	1	2	3	4	5	6	7	8	9	10
5. Swallow	0	1	2	3	4	5	6	7	8	9	10
6. Yawn	0	1	2	3	4	5	6	7	8	9	10
7. Talk	0	1	2	3	4	5	6	7	8	9	10
8. Smile	0	1	2	3	4	5	6	7	8	9	10

TASKS	Circle areas that increase your pain or you have difficulty with	Therapist's Comments
SELF CARE:		
Sleep Disturbance	Difficulty getting to sleep / Waking several times a night Pain in AM when waking up	
Washing oneself / caring for own body	Washing specific body parts: _____ Hair-care / Foot-care / Putting on shoes / Putting on or taking off clothes	
MOBILITY:		
Changing / Maintaining body position	Lying down / Squatting / Kneeling / Sitting / Standing Bending Transfers: In/out of car , In/out bed, In/out bath tub, Standing up from chair	Indicate max time able to maintain:
Carrying / Moving / Handling Objects	Lifting / Carrying Laundry, Child, Groceries, _____lbs Moving objects using lower extremities Hand / arm use when carrying / handling objects	
Moving around using Transportation	Checking Blind Spots, Pushing / Pulling Car Door, Steering wheel use, Clutch / Brake use	
Walking	<15min, 15-30 min, >30min	
Stair Climbing	Up Stairs, Down Stairs, Ladder	
DOMESTIC LIFE		
Acquisition of Necessities	Shopping	
Household Tasks	Prepping Meals , Vacuuming, Cleaning, Washing Dishes, Washing / Drying Clothes, Storing Food Prep / Cooking	
Caring / Assisting Others	Caring for Child(ren), Adult:	
MAJOR LIFE AREAS:		Knowledge of HEP: G - F - P
Work Duties:	Carry ____ lbs, Standing> _____min, Use of Computer □ Yes, □ No max time / day: ____hrs Lifting _____lbs, Sitting> _____ min / hrs, Talking > _____min/hrs Climb: □ stairs, □ Ladders, □ in / out trucks	Posture/ body mech: G - F - P

_____ _____

Patient Signature **Physical Therapist Signature**