PATIENT INFORMATION

Name: Last_______________________________First_________________ Middle:_________
Address:____
City:__________________________________State________________Zip:________________
Phone: (_____)__________________________Cell phone: (_____)______________________
Birth Date: ____/____/______ Age:_______Sex: Male______, Female_______
e-mail address

RESPONSIBLE PARTY / GUARANTOR

Name: Last_______________________________First_________________ Middle:_________
Address:____
City:__________________________________State________________Zip:________________
Phone: (_____)__________________________Cell phone: (_____)______________________
Birth Date: ____/____/______
Relationship (circle) self, Spouse, Child, Other

HOW DID YOU HEAR ABOUT ROBYN?

Doctor/Chiropractor/Therapist (PT, Trainer, Massage)___________________________________
Friend / Relative:______________________________ Phone Book______
Coach_________________________________University of Oregon________________________

PATIENT OR GUARDIAN SIGNATURE: DATE:

PATIENT INTAKE FORM

Name:_____________________________ Date:____________________________

REFERRED BY:____

1. Has your condition been diagnosed by a physician? Y/ N Date____________

2. If yes, please give the physician's name______________________________
   diagnosis:____

3. X-Ray? Y / N Date____________MRI Y/ N Dates_________________

4. CT scan Y / N Date___________ Bone Scan Y/ N Date______________

5. In your own words, try to describe **when and how** current problem
   started____
   ____
   ____
   ____

   ____

6. Development of symptoms after onset
   ____
   ____

7. Current symptoms____

   ____

8. On a scale of 1 to 10, ten being the worst, how severe were your symptoms at
   the time of the original injury?___________ During the past week?_______
   Today________? In the AM?__________ In the PM_________________
   With sedentary activities?______________ After activities?_____________

9. Swelling Y/ N When did it start?_____________ Location_______________

10. Have you had additional traumas or re-injury to the area?________________
If yes, When?____
Did you completely recover from this injury________________________________

11. In general do you think you are getting: better/worse/same

Name : __________________________ DATE:________________

12. What forms of treatment have you tried since the injury?_________________
____
13. Of these types of therapy, which have helped?__________________________
____
14. Which therapies, if any, have made you feel worse?_____________________

15. What have you found to relieve your symptoms?________________________

16. What makes you worse?____

17. Do the requirements of your job irritate your symptoms? Yes No

18. What have you eliminated from your routine in order to find relief?____

19. What medications are you currently taking?____________________________
____

20. Does your condition prevent you from getting to sleep?_______ Cause you to wake frequently?___________ Prevent a sound sleep?_________________ or cause you to get up earlier than desired?______________________________
How many hours of sleep do you get?_______What is normal for you?______

21. On a scale 1 to 10, how severe are your symptoms when you awaken?______

22. Do you feel better or worse as the day goes on?________________________

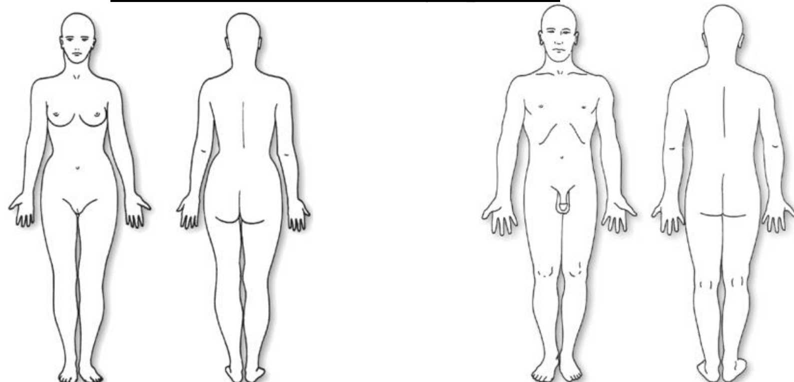
23. Do you use any special orthotic devices or braces? Lumbar support/ arch supports/heel lifts/ other?____

24. How much water do you drink daily?_________________________________

25. Do you drink coffee/caffeine?_______________ How much?_____________

26. Do you smoke?___________________ How many daily?________________

Please Mark areas of Symptoms:



Robyn Pester
Physical Therapy

MEDICAL HISTORY FORM

NAME____ Today's Date ________________

General Health: Excellent___ Good___ Average___ Fair___ Poor___

Stress Level: Low___ Medium___ High___

Are you currently seeing any of the following?

Medical Doctor Yes No Psychiatrist/Psychologist Yes No Chiropractor Yes No
Dentist Yes No Physical Therapist Yes No Other__________________

If you have seen any of the above in the last 3 months, please describe for what reason (Illness, medical condition, physical exam, etc.).

____

In the past 6 months, have you had:

Difficulty with bowel/bladder control Yes No Fever/Chills Yes No
Numbness Yes No Numbness in genital or anal area Yes No
Night Pain/Sweats Yes No Weakness Yes No
Vision/hearing problems Yes No Dizziness/Fainting Yes No
Bodily Discomfort Yes No Unexplained weight change Yes No
Chest Pain Yes No Shortness of Breath Yes No
Leg Swelling Yes No Other ________________________________

Heart Problems Yes No Chemical Dependency / Alcoholism Yes No
Depression Yes No High Blood Pressure Yes No
Hepatitis Yes No Stroke Yes No
Asthma Yes No Tuberculosis Yes No
Anemia Yes No Emphysema / Bronchitis Yes No
Rheumatoid Arthritis Yes No Kidney Disease Yes No
Thyroid Problems Yes No Other Arthritic Conditions Yes No
Allergies Yes No Diabetes Yes No
Epilepsy / Seizures Yes No Multiple Sclerosis Yes No
HIV / Acquired Immune Deficiency Syndrome Yes No Other __________________________

Do you have any of the following risk factors for Heart Disease?

High Blood Pressure Yes No Diabetes Yes No
High Cholesterol Yes No Smoking Yes No
Heart Disease Yes No Family history of heart disease Yes No

Please list any surgeries or conditions for which you have been hospitalized which may pertain to your current condition. Include the reason for the surgery / hospitalization and approximate date.

DATE SURGERY / HOSPITALIZATION

__________ ____
__________ ____
__________ ____

What Prescription Medications are you currently taking and at what quantity (including pills, injections, and skin patches)?

____