# OUTPATIENT PHYSICAL AND OCCUPATIONAL THERAPY INTAKE FORM

Patient Name: ____________________ Date of Birth: ______ Today's Date: ____________

Please answer these questions to the best of your ability:

1. What problem brings you to therapy? (check all that apply) □ Brain Injury □ Balance Issue
   □ Car accident □ Joint Pain □ Spine Injury □ Lymphedema □ Work Injury □ Stroke
   □ Walking problem □ Sports Injury □ Cancer □ Amputation: where? ______________
   □ Post-Surgical: where?:__________________ □ Other: _____________________________
2. When did this problem start? Date of surgery: _______ Date of accident: _______
   Date of Injury/Illness: ____________ or □1-3 months ago □ 3-6 months ago
   □ 6-12 months ago □ more than 1 year ago □ 1-2 years ago □ more than 2 years
3. Which body part is affected? □ Neck □ Back □ Shoulder □ Elbow □ Wrist □ Hand
   □ Hip □ Knee □ Ankle □ Foot □ Other: _________________________________________
4. Which side is affected? □ Right □ Left □ Both
5. What is your pain level on a scale of **0-10** (0 being no pain, 10 being maximum pain)?
   Circle: **0 1 2 3 4 5 6 7 8 9 10** Where is the pain located? ________________________
6. Did you have any Tests for your injury? □ XRay: Date ______ Where ___________
   □ MRI: Date_____ Where _______ □ CT Scan: Date _____ Where ___________
   □ Other___________ Date _______ Where ___________
7. What was your activity level prior to injury/illness? □ High □ Medium □ Low
8. Did you play any sports or have active hobbies prior to injury/illness? □ No □ Yes
   Please List: ______________________________________________________________
9. Did you use a cane or a walker prior to your injury/illness? □ No □ Yes: How long? ______
10. Did you have an inpatient rehabilitation stay for your injury/illness? □ No □ Yes
    When? _____________ Discharge Date? ________ Where? ________________________
11. Did you have any Homecare PT or OT for your injury/illness? □ No □ Yes
    How long? ___________________________ Ending date? _________________
12. Do you use any equipment at home to help you with self-care? □ No □Yes: List: _________
    ___________________________________________________________________________
13. What goal would you like to accomplish with therapy? ______________________________

**I certify the above information is true to the best of my knowledge and ability.**

_____________________________
Patient/Representative Print Name

_____________________________ _______________ __________________
Patient/Representative Signature Relationship Date