# Rehabilitation Services Intake

Welcome! Please fill this out to the best of your ability and return it to the front desk. Thank you!

Date: _____ Date of Injury/Start of symptoms: _____

Reason for visit (pain, balance, etc.): _____

Height: _____ Weight: _____ Occupation: _____

Gender: _____ Pronouns (circle): She/Her He/Him They/Them Other

What do you do in your free time/what are your hobbies? _____

_____

What is a realistic goal that you would like to achieve with therapy? _____

_____

Is there anything else you would like for us to be aware of? _____

_____

| We want to know **your goals** to help us guide your care. Please list three important activities below that you are currently having difficulty with or cannot do. | **0** = **Unable** to perform the activity | | | | | | | | | **10** = **Able** to perform the activity at the same level as before the injury or problem |
|---|---|---|---|---|---|---|---|---|---|---|
| **What activities do you find difficult because of your injury or problem? Please list them below and mark your current rating.** | **CURRENT RATING** | | | | | | | | | |
| | **0** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** |
| 1. | | | | | | | | | | | |
| 2. | | | | | | | | | | | |
| 3. | | | | | | | | | | | |

**Please check any symptoms that you are currently experiencing:**

- ☐ Fever/Chills/Sweats
- ☐ Poor balance (falls)
- ☐ Unexplained weight loss
- ☐ Numbness or Tingling
- ☐ Changes in appetite
- ☐ Difficulty swallowing
- ☐ Depression
- ☐ Shortness of breath
- ☐ Dizziness
- ☐ Headaches
- ☐ Nausea/Vomiting
- ☐ Increased pain at night
- ☐ Fatigue
- ☐ Difficulty sleeping
- ☐ Difficulty concentrating/thinking
- ☐ Changes in bladder or bowel function

**Please check any medical or surgical history we should be aware of:**

- ☐ Arthritis
- ☐ Heart Condition
- ☐ Spinal Cord Injury
- ☐ Blood Clots
- ☐ Hernia
- ☐ Stroke/TIA
- ☐ Blood Disease
- ☐ High Blood Pressure
- ☐ Thyroid Disorder
- ☐ Cancer
- ☐ High Cholesterol
- ☐ Vision Problems
- ☐ Diabetes
- ☐ Kidney Disease/Dialysis
- ☐ Memory Problems
- ☐ Drug-Resistant Infection
- ☐ Liver disease/Hepatitis
- ☐ Other: _____
- ☐ Epilepsy/Seizures
- ☐ Lymphedema
- Are you pregnant/nursing? ☐ Yes ☐ No
- ☐ Fibromyalgia
- ☐ Multiple Sclerosis
- Do you smoke? ☐ Yes ☐ No

Are you allergic to latex and/or adhesives? ☐ Yes ☐ No

**Have you received any other therapy or alternative care treatments this calendar year?**

☐ Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy
☐ Chiropractic Treatment ☐ Acupuncture ☐ Massage Therapy

How many visits did you have?: _____ Clinic Name: _____

## Falls

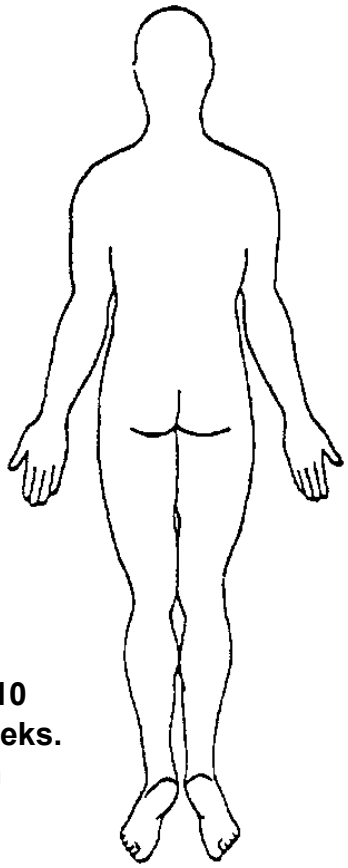
Are you worried about falling or losing your balance? ☐ Yes ☐ No ☐ _____

How many falls or near-falls have you had in the past 6 months? _____

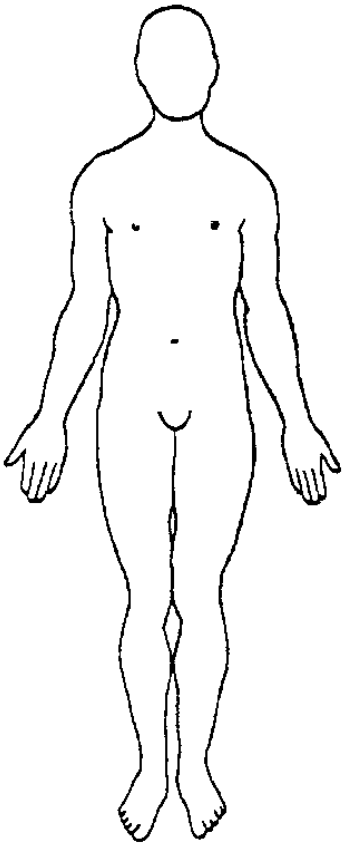
## Body Chart:

On the body diagrams below, please mark the areas where you have symptoms.

(Left) – **Back** – (Right)



(Right) – **Front** – (Left)



**Circle all that apply:**

Shooting/sharp pain

Dull/aching pain

Numbness

Tingling

**My Symptoms Currently:**

☐ Come and go

☐ Are constant

☐ Are constant, but change with activity

**Please rate your pain from 0 – 10 over the last couple of days/weeks. 0 = no pain, 10 = the worst pain imaginable.**

My Pain Currently: _____

My Pain At Its Lowest: _____

My Pain At Its Highest: _____

My symptoms are worse with: _____

My symptoms are better with: _____