MCPT Patient Intake Form

(Please complete front page and bring to your first appointment)

Name: ______________________ **Birthdate:** ____________ **Age:** ______ **Occupation:** ____________________

How did this occur? ____________________________ ☐ Unsure **Date of onset**: _______ ☐ gradual ☐ sudden

Current symptoms: ☐ decreased motion ☐ weakness ☐ swelling ☐ tingling/numbness **Pain** (0-10 scale)____/10

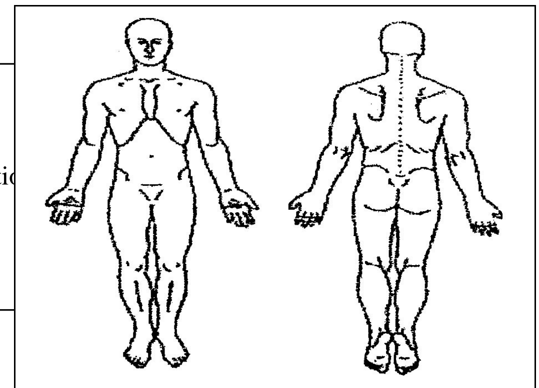
Have you fallen in the past year? ☐ Yes ☐ No If yes: How often? _________________________

Aggravating factors: (CHECK 3) ☐ am ☐ pm ☐ as day progresses ☐ standing ☐ walking ☐ sitting ☐ turning your head ☐ reaching ☐ sleeping ☐ running ☐ recreation ☐ sit to stand ☐ cough/sneeze ☐ squatting ☐ stairs ☐ repetition ☐ bending

Easing factors: (CHECK 3) ☐ am ☐ pm ☐ as the day progresses ☐ standing ☐ walking ☐ sitting ☐ bending ☐ squatting ☐ reaching ☐ sleeping ☐ heat ☐ meds ☐ cold ☐ being still ☐ being on the move

This problem is getting (since the onset): ☐ better ☐ same ☐ worse

Please mark area of **pain location:**



Previous injury to this area: ☐ no ☐ yes (specify) __________________

Previous providers seen include: ________________________________

Previous treatment: ☐ surgery ☐ medication ☐ injection ☐ manipulatio ☐ exercise ☐ rest ☐ immobilization ☐ heat ☐ ice ☐ massage ☐ none

Tests: ☐ x-rays ☐ MRI ☐ EMG ☐ CAT scan ☐ other: __________

RESULTS: ____

List current Meds: ____

Current work status: ☐ full/part time ☐ homemaker ☐ not working ☐ expected date of return: ______________

☐ Modified duty: ☐ specific restrictions: ____

How will you know you are better? ____

Functional assessment:	**1= normal**	**2=mild difficulty**	**3=moderate difficulty**	**4=severe difficulty**
balance	1	2	3	4
bending	1	2	3	4
dressing/grooming	1	2	3	4
sitting/driving	1	2	3	4
gripping	1	2	3	4
keyboarding	1	2	3	4
lifting/carrying	1	2	3	4
moving your head	1	2	3	4
reaching	1	2	3	4
recreational pursuits	1	2	3	4
sit to stand	1	2	3	4
sleeping	1	2	3	4
squatting	1	2	3	4
stairs	1	2	3	4
standing	1	2	3	4
walking	1	2	3	4

Other medical history: (please check those that apply to yourself)

☐ headaches	☐ polio	☐ respiratory disease
☐ cancer	☐ diabetes	☐ high blood pressure
☐ HIV	☐ seizures	☐ heart disease
☐ mental illness	☐ dizziness	☐ chemical dependency
☐ hepatitis	☐ skin disorders	☐ neurologic disease
☐ smoking	☐ osteoporosis	☐ arthritis (rheumatoid)

other: ____