

Magee Outpatient Therapy Initial Intake Form

Name: _____ DOB: _____ MR#: _____

Diagnosis: _____ Physician Name: _____

History of current problem:

- What is the problem?
- Onset date for problem (mm/dd/yyyy):
- What caused the problem?
- Have you had this problem before? (please circle): YES NO
- Did you get better? (please circle): YES NO SOMEWHAT
- What made it better/ worse?
- Have you had prior therapy for this condition?

Medical History

- Do you have an out of hospital DO NOT RESUSCITATE ORDER? YES NO

Have you ever been diagnosed with or treated for the following (hospitalization included)?

PLEASE CHECK ALL THAT APPLY!

	YES	DATE		YES	DATE
Alcohol abuse			Falls/ loss of balance		
Anemia			Gallbladder disease		
Arthritis/ rheumatism/ gout			Head injury/ loss of consciousness		
Asthma			Heart problems		
Bleeding tendency			Hepatitis		
Bowel disorder/ colitis			High blood pressure		
Cancer/ tumors			Kidney, bladder, prostate problems		
Depression			Phlebitis		
Diabetes			Stomach problems/ ulcers		
Drug abuse			Nervous/ emotional problems		
Emphysema/bronchitis			Stroke		
Epilepsy			Tuberculosis		

Have you had surgery for any reason including any of the above conditions?

YES NO. If yes, please list and include dates:

PATIENT NAME: _____ MR#: _____

Have you had any of the following within the past year? (PLEASE CIRCLE)

- | | |
|------------------------|---------------------|
| Bowel | Hearing problems |
| Chest pain | Heart palpations |
| Coordination problems | Hoarseness |
| Cough | Joint pain swelling |
| Difficulty sleeping | Loss of appetite |
| Difficulty swallowing | Nausea/ vomiting |
| Dizziness/ blackouts | Night pain |
| Falls/ Balance problem | Shortness of breath |
| Fever/ chills/ sweat | Urinary problems |
| Headaches | Vision problems |

Other: _____

Please EXPLAIN any circled items:

Medications:

Any known adverse and allergic drug reaction: N/Y _____

Prescription medications: _____

Non prescription medications: _____

Vitamins/ minerals/supplements: _____

Have you had any significant weight gain/ loss (> 10 pounds) in the past month?

YES NO. If yes, how much? _____ pounds

The following questions ask about your PAIN.

PAIN SCALE: 0 (no pain)-----10 (worst pain)

At WORST, my pain is 0 – 10:

At BEST, my pain is 0 – 10:

Pain currently limits which of the following? (Please circle ALL that apply)

Locomotion/ movement

Walking (at home, level ground, uneven ground, ramps, curbs, stairs)

Standing

Sitting

Self care (bathing, dressing, eating, and toileting)

Home management (cleaning, shopping, chores)

Getting in and out of bed

Lifting

Bending

Driving

Work activities

Leisure activities

Other: _____

PATIENT NAME: _____ MR#: _____

SOCIAL HISTORY

Health Habits:

Do you smoke? YES NO # _____ packs per day Quit (year) _____

How many days do you exercise in an average week?

How long is your exercise session?

Describe the exercise:

Employment (Please circle ALL that apply)

Occupation:

Full time Part time Unemployed Retired
Inside home Disability Student

If you are not currently working, do you plan to return to work? YES NO

Are you interested in changing jobs? YES NO

Where do you live? (Please circle ALL that apply)

Alone Parent Spouse Children Significant other

Parent (please specify): _____

Other Relative (please specify): _____

Other (please specify): _____

Do you have any attendant care? YES NO Hours/day _____ Days/week _____

HOME SET UP:

steps to enter: _____ with right rail/ left rail ramp elevator

steps to go upstairs: _____ with right rail/ left rail stair glide

steps to go to basement: _____ with right rail/ left rail

Do you use any medical equipment?

Cane Quad cane Crutches Walker (without wheels) Walker (with wheels)

Manual wheelchair Power wheelchair

Other: _____

Cultural/ Religious:

Do you have any customs or religious beliefs that may affect care? YES NO

List 4 goals for therapy

- 1.
- 2.
- 3.
- 4.

Do you have any other concerns or needs that we can be of assistance with?

PATIENT NAME: _____ MR#: _____

Discussed cancellation and no-show policy with patient? (Please circle ONE)

YES NO

Patient's initials: _____

CLINICIAN USE ONLY

Learning preferences (please circle ALL that apply)

1. Understands and can apply basic information:

YES NO SOMEWHAT (requires reinforcement)

2. Learning readiness: ready not ready no interest declines

3. Learning barriers: none vision hearing language/ interpreter needed
unable to read/ comprehend what is read

Other: _____

4. How does patient best learn? Pictures reading listening demonstration

Other: _____

Therapist's signature(s) _____

Date: _____

Date: _____