Capitol Physical Therapy | Associated Physicians — Devoted Physicians, Trusted Care.

Intake Form

Are you a former CPT patient or a friend/family member of a former patient? ☐ ***Yes*** ☐ ***No***

I. Personal Information

Name: _____ Date:_____

Occupation: _____ Employer: _____

Describe your usual exercise routine:_____

II. Medical History: Have you ever been diagnosed with or do you have any of the following conditions?

(Check all that apply)

☐ **None of these apply to me**

☐ Cancer
☐ Heart problems
☐ Chest pain/angina
☐ Circulation problems
☐ Blood clots
☐ Stroke
☐ Anemia
☐ Chemical dependency (i.e. alcoholism)
☐ Depression
☐ Anxiety
☐ Lung problems
☐ Tuberculosis
☐ Sexually transmitted disease/ HIV
☐ Rheumatoid Arthritis
☐ Arthritis
☐ Bladder/urinary tract infection
☐ Kidney problems/infection
☐ Cholesterol high/low
☐ Thyroid problems
☐ Diabetes
☐ Osteoporosis
☐ Multiple Sclerosis
☐ Epilepsy
☐ Hepatitis
☐ Ulcers
☐ Liver problems
☐ Allergies/asthma
☐ Pacemaker
☐ Blood thinners
☐ Fibromyalgia
☐ Broken bones
☐ Recent infection /illness (explain)
☐ Other

Past surgical history (list & date): _____

III. How did you hear about our clinic?

☐ My doctor's office ☐ I am referring myself for PT ☐ Family/friend/colleague recommended ☐ My insurance company said you were in my network ☐ I did a search on the internet ☐ My trainer ☐ Another PT sent me ☐ Other_____

Please tell us who we can thank for sending you our way:_____

IV. Current Symptoms Problem(s) you are here for: _____

What date (roughly) did your symptoms start? _____What do you think started your symptoms? _____

Are your symptoms related to a work injury? Yes No Or a motor vehicle accident? Yes No

Treatments so far for this problem (injections, chiropractic, etc.): _____

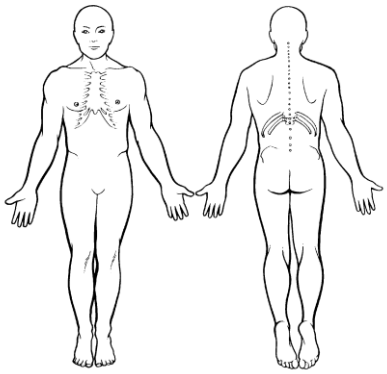
Have you had an X-ray, MRI, or other imaging for this problem? Yes No If yes, please list, including date: _____

Have you ever had this before? Yes No

If yes, when and how it was treated: _____

What is your personal goal for therapy? _____

Body chart: Please mark **all** areas where you feel symptoms on the chart to the right



What makes your symptoms **better**? _____

What make your symptoms **worse**? _____

On the scale below, please mark the number which best represents the severity of your pain over the past 24 hours:

0 1 2 3 4 5 6 7 8 9 10

No Pain Worst pain imaginable

SINCE YOUR SYMPTOMS BEGAN, have you noticed any of the following?

(Check all that apply)

- ☐ Fatigue
- ☐ Generalized muscle weakness
- ☐ Pain at night
- ☐ Leg swelling
- ☐ Weight loss/gain
- ☐ Difficulty maintaining balance when walking
- ☐ Changes in bowel or bladder function
- ☐ Changes in cognition
- ☐ Skin changes
- ☐ Numbness or tingling
- ☐ Falls
- ☐ Shortness of breath
- ☐ Heartburn/indigestion
- ☐ Difficulty swallowing
- ☐ Headaches
- ☐ Changes in appetite
- ☐ Heart palpitations
- ☐ Fever/chills/sweats
- ☐ Nausea/vomiting
- ☐ Abdominal pain
- ☐ Fainting
- ☐ Cough
- ☐ Chest pain especially with sweats
- ☐ Other
- ☐ **None of these apply to me**

During the past month have you been feeling down, depressed, or hopeless? Yes No

During the past month have you been bothered by having little interest or pleasure in doing things? Yes No

Is depression or anxiety something you would like help with? Yes Yes, but not today No

Do you ever feel unsafe at home, or has anyone tried to hit or injure you in any way? Yes No

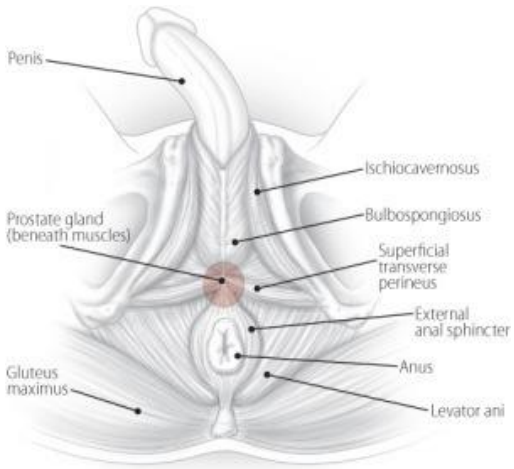
If you are over 65, how many falls have you had in the last 6 months? _____

Are you taking any medications? ☐ No ☐ Yes ☐ Associated Physicians has my medications on file ☐ Med list is attached

Patient Signature:_____

Capitol Physical Therapy

Please mark the areas where you feel pain:



GENITAL REPRODUCTIVE SYSTEM

History of:

☐ Genital Herpes? ☐ Urinary tract or bladder infections?
☐ Blood in urine? ☐ Kidney Stones? ☐ Current infections?
☐ Recent change in penile discharge? ☐ Prostate cancer?
☐ Benign Prostatic Hypertrophy (BPH)?

Do you use:

☐ Latex condoms ☐ KY Jelly

URINARY/BLADDER HISTORY: (Check all that apply)

Do you:

☐ Urinate more than one every 2 hours?
☐ Have a sense of "urgency" to urinate?
☐ Have difficulty initiating urine/hesitancy?
☐ Have symptoms of leaking urine?
☐ Have blood in your urine?
☐ Have odor?
☐ Have painful urination?
☐ Have recent changes in urine color?
☐ Have Interstitial Cystitis/Painful Bladder?
☐ Wake to urinate? If yes, how many times _____

BOWEL HISTORY: (Check all that apply)

Do you:

☐ Leak gas or feces? ☐ Have irritable bowel syndrome (IBS)?
☐ Have constipation?

PELVIC SURGERY HISTORY: (Check all that apply)

Have you had: ☐ None
☐ Laparoscopy? ☐ Gall bladder surgery?
☐ Any pelvic organ surgery?

CURRENT SEXUAL ACTIVITY: (Check all that apply)

☐ Sexually Inactive due to PAIN ☐ Sexually active ☐ Sexually inactive for other reasons

If you are sexually active, continue with this section: (Check all that apply)

☐ No pain with intercourse
☐ Pain with intercourse, able to complete sex
☐ Pain with intercourse disrupts or prevents sex
☐ Pain with intercourse prevents any attempt to have sex
☐ Tolerate manual or oral stimulation only/no penetration
☐ Abnormal discharge
☐ Impotence
☐ Difficulty with erection
☐ Painful ejaculation
☐ Cramping pain after ejaculation
☐ Blood in semen

CHECK ALL THE ACTIVITIES THAT CAUSE OR INCREASE PAIN: (Check all that apply)

☐ Urination after intercourse
☐ Partner manual stimulation
☐ Friction with clothing
☐ Sports activities
☐ Urination in general
☐ Oral stimulation
☐ Masturbation
☐ Other:

CHECK THE WORDS THAT DESCRIBE YOUR PAIN: (Check all that apply)

☐ Hot
☐ Burning
☐ Scalding
☐ Searing
☐ Sharp
☐ Cutting
☐ Tearing
☐ Tiring
☐ Exhausting
☐ Frightful
☐ Punishing
☐ Grueling
☐ Suffocating
☐ Sickening
☐ Annoying
☐ Troublesome
☐ Miserable
☐ Intense
☐ Unbearable
☐ Discomforting
☐ Other

WHAT MAKES YOUR PAIN BETTER: (Check all that apply)

☐ Heating pad
☐ Ice pack
☐ Resting in bed
☐ Resting in chair
☐ Medication
☐ Cream
☐ Abstaining from sexual intercourse
☐ Not wearing tight clothes
☐ Other: _____

WHAT TREATMENTS HAVE YOU HAD FOR THIS PROBLEM? (Check all that apply)

☐ None

☐ Medication:_____ ☐ It has helped ☐ It hasn't helped
☐ Surgery:_____ ☐ It has helped ☐ It hasn't helped
☐ Physical Therapy _____ ☐ It has helped ☐ It hasn't helped

FLUID INTAKE: How many of each do you drink every day?

____ 8 ounce glasses of water
____ cans of diet soda
____ cans of regular soda
____ 8 ounce cups of regular coffee
____ 8 ounce cups of decaf coffee
____ 8-ounce cups/glasses of tea
____ 16-ounce cans of beer
____ glasses of wine
____ glasses of liquor
____ 8-ounce glasses of milk
____ 8-ounce glasses of juice
Other_____

SKIN CONDITIONS:

Eczema? _____Contact dermatitis?_____
Psoriasis?_____ Other? _____