Orthopedic Intake

COOPERATIVE PERFORMANCE & REHABILITATION

Name: _____ Date: _____ Date of Injury Onset:_____

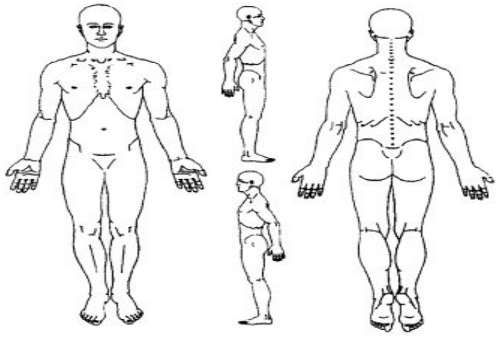
Occupation: _____ Status: ○ Full Time ○ Part Time ○ Other_____

History of Present Condition:_____
_____
_____
_____
_____

What is your Primary Concern/Chief Complaint:_____
_____
_____
_____
_____

PAIN:

If you are having pain, please rate the severity on a 0-10 scale, where 0 is no pain and 10 is the most severe pain:											
At Worst	0	1	2	3	4	5	6	7	8	9	10
At Best	0	1	2	3	4	5	6	7	8	9	10
Current	0	1	2	3	4	5	6	7	8	9	10



Please Indicate the location of your symptom above.

Pain Description: _____
_____

What makes your symptoms better: _____
What makes your symptoms worse: _____

Previous History of same complaint? No ▯ Yes ▯ If so how many times? _____
Year of first occurrence: _____

Have you received previous treatment for similar symptoms (if so **please describe**)?_____
_____

History of falls? No ▯ Yes ▯ If yes how often?_____ When was last fall?_____

Medical History: (circle all that apply)

Osteoporosis	Surgical History	Seizure/ Epilepsy	Anemia	Hernia
Arthritis	Previous Therapy	Numbness/ Tingling	Headaches	Anxiety
Diabetes 1 or 2	Cardiovascular Disease	Head Injury/ Concussion	Thyroid Problems	Asthma
Cancer	Fibromyalgia	Shortness of Breath	Depression	Other

Please Describe any circled items: _____
_____

Surgical History (type/date): _____

Current Medications:
Prescriptions ☐ Vitamins ☐
Over the Counter ☐ Herbals ☐ See med list in eDocs ☐
List of Medications:_____

Imaging:
(X-Ray, MRI, EMG, etc):
_____
_____

BMI: Height_____ Weight_____

Please list your goals for therapy:_____
_____

_____ _____
Patient/Parent/Guardian Signature **Date**

Administrative Staff: please attach appropriate outcome measure per affected body part (see below)

Body Region	Outcome Measure
Neck	Neck Disability Index (NDI)
Hand/Elbow/Shoulder	Extremity Functional Scale
Back	Oswestry
Hip/Knee/Ankle	Lower Extremity Functional Scale
Other	As directed by clinical staff