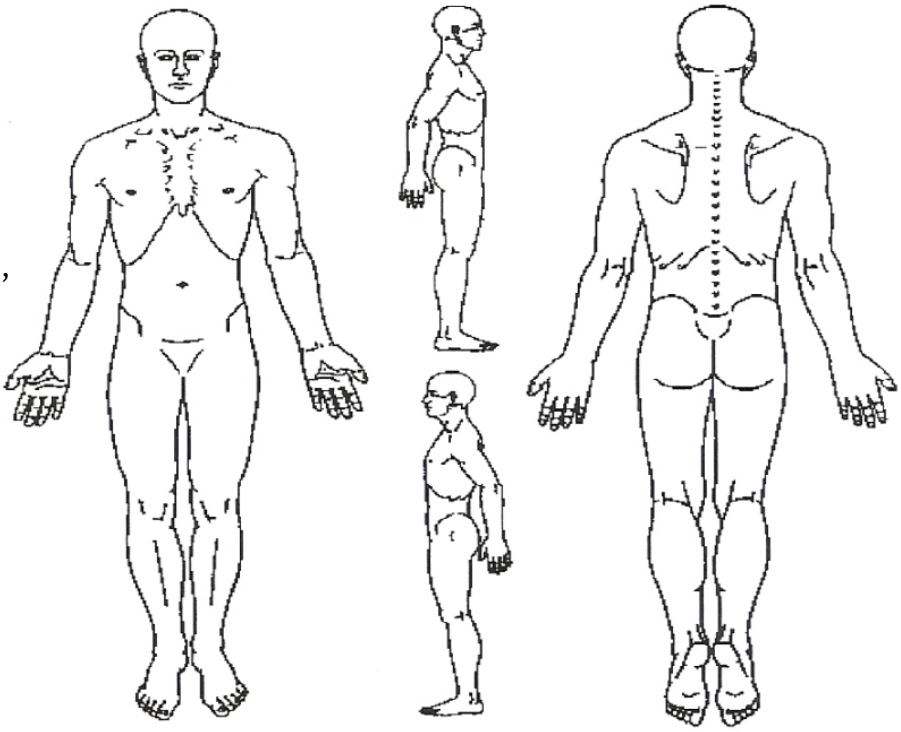
New Patient Intake

Patient: _____ Date: _____

***Shade in areas of pain, numbness, or tingling.



Describe Pain:_____

_____

Describe any muscle weakness and any functional difficulty, i.e. tripping, difficulty with stairs, etc?

_____

How long have you had this problem? _____

Any loss of bowel control? _____YES _____NO_____
Any loss of bladder control? _____YES _____NO_____
Any loss of sexual function? _____YES_____ NO_____

Previous testing/x-rays/lab/others (regarding this problem)

_____

Briefly describe the type of work you do: _____

Are you currently working? YES or NO Are you currently on modified duty? YES or NO

2100 NE Broadway, Suite 225 Portland, OR 97232
P: 503-719-5000 F: 971-255-1754

PDX Bodyworks Physical Therapy, LLC

Health History

NAME: _____ DATE OF BIRTH: _____

OCCUPATION: _____ EMPLOYED BY: _____

ADDRESS: _____ CITY: _____

STATE: _____ ZIP: _____ E-MAIL: _____

WHAT, IF ANY, OTHER HEALTH PROBLEMS HAVE YOU HAD?
PLEASE MARK BELOW ALL THAT APPLY TO YOU:
____ Diabetes/ ____ Cancer/ ____ High Blood Pressure/ ____ Heart Problems/____ Anemia/
____ Asthma, Hay Fever/ ____ Thyroid Problem/ ____ Kidney, Bladder or Urinary Problem
____ Lung Problems/ _____ Stomach or Bowel Problems/ _____ Liver Problem or Hepatitis
____ Birth Defects/ ____ Arthritis/ ____ Glaucoma/____ Venereal Disease
OTHER NOTES: _____
_____
_____

SURGERIES (LIST PROCEDURE AND YEAR): _____
_____
_____

HOSPITALIZATIONS (OTHER THAN SURGERIES AND CHILBIRTH/REASON AND YEAR):
_____
_____

ALLERGIES (MEDICATIONS OR OTHERS):
_____
_____

LIST MEDICATIONS TAKEN ON A REGULAR BASIS, INCLUDING OVER THE COUNTER, HERBAL, ETC:
_____
_____
_____

HABITS:
ALCOHOL: NONE____
ALCOHOLIC BEVERAGES PER WEEK, 1-4____, 5-7____, MORE THAN 10-15____
TOBACCO: NONE____
CIGARETTES_____, PACKS PER DAY FOR _____ YEARS
CIGARS, PIPE _____

OTHER INFORMATION THAT MAY AID IN YOUR CARE: _____
_____
_____

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