WPT

FUNCTIONAL ASSESSMENT INTAKE SHEET

Name: ________________________________ Age: ______________

Medical History
Check the box if you have had any of the following:

_____Diabetes	_____Varicose veins	_____Neurological problems
_____Rheumatic fever	_____Circulatory problems	_____Stroke
_____Heart murmur	_____Lung disease	_____Broken bones (fracture)
_____High blood pressure	_____Epilepsy/seizures	_____Kidney disease
_____Heart disease/pacemaker	_____Cancer	_____Liver disease
_____Migraine headaches	_____Arthritis	_____Metal implants
_____Osteoporosis	_____Other…explain________________________________	

List any significant hospitalizations and surgical procedures/reasons/dates: ___________________
____
____
____

List any medications that you are presently on: ____
____
____

Do you have any skin or medication allergies? Yes_____No_____If so, which?________________
____

Is there a chance you may be pregnant at this time?Yes_____No_____
Do you smoke?_____cigar/cigarettes/pipe. How much? _____When did you quit?______________

BRIEFLY GIVE HISTORY OF ILLNESS YOU ARE NOW REFERRED TO PHYSICAL THERAPY FOR. ALSO INCLUDE SYMPTOMS.______________________________________
____
____
____

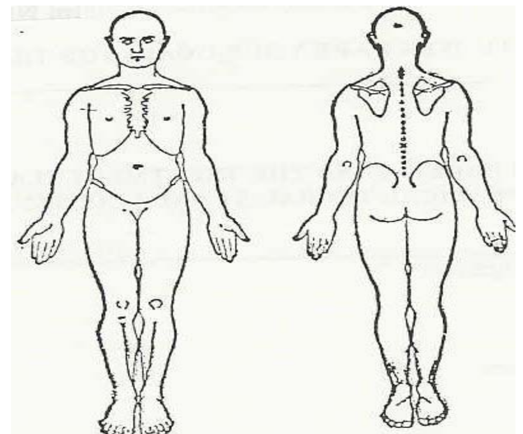
Is the pain constant/intermittent? ____
Does the pain radiate? Where? ____
____
What makes it feel better? ____
What makes it feel worse?____
Describe the pain: ____
Rate the pain intensity on a scale of 1-10 (10 the worst pain):

0 1 2 3 4 5 6 7 8 9 10

No pain Excruciating pain

USING THE DIAGRAM AT RIGHT
SHOW THE LOCATION OF PAIN

DULL ACHE: BURNING
STABBING NUMBNESS
PINS & NEEDLES



Please turn over

FUNCTIONAL ASSESSMENT

ANSWER THE FOLLOWING QUESTIONS, *IF APPLICABLE*:

1. Do you find it difficult to change positions? Describe ____________________________
   ____
   Do you find it difficult to lie down? Yes_____ No_____
   To come to a sitting position from lying down? Yes_____ No_____
   Do you have trouble getting up from a chair? Yes_____ No_____

2. Do you have trouble putting on your shoes and socks? Yes_____ No_____

3. I walk for ________minutes before needing to rest.

4. I stand for ________minutes before needing to sit.

5. I sit for __________minutes before needing to change positions/get up

6. Do you have difficulty stairclimbing? Yes_____ No_____

7. How often during the day do you need to lie down and rest?________________________

8. Do you engage in regular exercise? Yes_____ No_____ What type and how often?_____
   ____

   Are you able to exercise now? Yes_____ No_____

9. Do you have discomfort, shortness of breath or pain with exercise?____________________

10. Do you work? Yes_____ No_____ What is your occupation?________________________

11. In general, your lifestyle is: 1 2 3 4 5
    active average inactive

12. Do you presently see a chiropractor? No_____ Yes___
    Other physical therapist? No_____ Yes___ Whom: ______________________

13. WHAT ARE YOUR GOALS FOR THERAPY? ___________________________________
____

I UNDERSTAND THE TREATMENT PLAN OUTLINED AND EXPLAINED TO ME BY THE PHYSICAL THERAPIST AND I CONSENT TO THE TREATMENT.

____
Signature Date