EVALUATION INTAKE FORM – Please fill in **ALL** blanks. Write N/A, for not applicable.
Name (Last, First, MI): _____ DOB: _____ Sex: _____ Date: _____
Who referred you to MSPT? ☐ Doctor _____ ☐ Self ☐ Friend ☐ Other_____ Dominant hand: ☐ Right ☐ Left

LIVING ENIRONMENT:
Type: ☐ House ☐ Condo ☐ Apt. ☐ Other_____ ☐ Stairs ☐ Railings ☐ Ramps ☐ Elevator ☐ Other _____
☐ Alone ☐ Spouse ☐ Children (ages) _____ ☐ Roommate(s) ☐ Pets ☐ Other _____
Assistive Devices: ☐ Wheelchair ☐ Walker ☐ Cane/Crutch ☐ Other Assistive Device _____

EMPLOYMENT:
Occupation: _____ ☐ Full-Time ☐ Part-Time | ☐ Retired ☐ Unemployed ☐ Student
From: ☐ Home ☐ Office If not working, list last date worked:_____

SOCIAL/HEALTH HABITS:
Coffee/caffeinated beverages: ☐ Yes ☐ No; Cups/day ☐ 0-1 ☐ 2 ☐ 3 ☐ 4+
Alcohol: ☐ Yes ☐ No; Days/week ☐ 0-1 ☐ 2 ☐ 3 ☐ 4+; Drinks/day: ☐ 0-1 ☐ 2 ☐ 3 ☐ 4+;
Smoking: ☐ Tobacco ☐ Marijuana ☐ None | ☐ I Quit; Year(s) quit:_____; Total Years: ☐☐
History of substance dependency / abuse: ☐ Yes ☐ No
Other drug use: _____

EXERCISE/ACTIVITY: ☐ Yes ☐ No
Type(s): Currently: _____ Previously: _____
Days/week: ☐ 0- 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5+; Hours/day: ☐ 0- ½ ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5+
History of sport (type, years played, injuries): _____

GENERAL PHYSICAL/EMOTIONAL HEALTH:
Rate your health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Recent life changes: ☐ Moving ☐ Employment ☐ Marriage/Divorce ☐ Childbirth ☐ Death in family ☐ Other: _____
☐ Yes ☐ No; Do you often worry about causing permanent damage to your body?
☐ Yes ☐ No; Have you felt down, depressed, or hopeless recently?
☐ Yes ☐ No; Have you been bothered by having little interest or pleasure in doing things recently?
☐ Yes ☐ No; Do you feel unsafe or has anyone tried to hit/injure you in any way?
☐ Yes ☐ No; Are you currently seeing a mental healthcare professional? Name: _____ How long/often: _____
☐ Yes ☐ No; Are you interested in getting in contact with a mental health professional?

OTHER CLINICAL PROVIDERS: Check all that apply, including current, previous, and unrelated conditions

☐ Acupuncturist	☐ Internist	☐ Naturopathic Doctor	☐ Orthopedist	☐ Rheumatologist
☐ Chiropractor	☐ Massage Therapist	☐ Obstetrician/Gynecologist	☐ Osteopath	☐ Other_____
☐ Dentist	☐ Neurologist	☐ Occupational Therapist	☐ Podiatrist	_____

OTHER CLINICAL TESTING: Check all that apply, including current, previous, and unrelated conditions

☐ Xray	☐ Blood Test	☐ Angiogram	☐ Pulmonary Func. Test
☐ MRI	☐ Urine Test	☐ EKG/Echocardiogram	☐ Other_____
☐ CT	☐ NCV (Nerve Con. Vel.)	☐ Stress Test	_____
☐ Bone Scan	☐ Arthroscopy/gram	☐ Biopsy	_____

MISC.
Eyewear: ☐ Glasses ☐ Contacts ☐ None; Prescription, if known:_____
Earwear (hearing aides or other assistive devices): ☐ Yes ☐ No; Describe: _____
Foot Orthotics (OTC, prescribed, etc.): ☐ Yes ☐ No; Describe: _____
Oral Orthotics (splints, night guards, etc.): ☐ Yes ☐ No; Describe: _____

MEDICAL HISTORY: Please check both **current** and **past** conditions. If applicable, please **list / describe** in space provided.

☐ Allergies:	☐ Dizzy Spells:	☐ MRSA / Repeated Infections:
☐ Anemia:	☐ Emphysema/Bronchitis/Lung Problems:	☐ Multiple Sclerosis:
☐ Anxiety:	☐ Fibromyalgia:	☐ Muscular Disease:
☐ Arthritis:	☐ Fractures:	☐ Osteoporosis / Osteopenia:
☐ Asthma:	☐ Gastrointestinal Problems:	☐ Parkinson's Disease:
☐ Autoimmune Disorder:	☐ Headaches/Concussions:	☐ Rheumatoid Arthritis:
☐ Cancer:	☐ Hearing Impairment:	☐ Seizures:
☐ Cardiac Conditions:	☐ Hepatitis:	☐ Smoking:
☐ Cardiac Pacemaker:	☐ High Cholesterol:	☐ Speech Problems:
☐ Chemical Dependency:	☐ High/Low Blood Pressure:	☐ Stroke:
☐ Circulatory / Vascular Problems:	☐ HIV/AIDS:	☐ Thyroid Disease:
☐ Currently Pregnant:	☐ Incontinence/ Bowel Problems:	☐ Tuberculosis:
☐ Depression:	☐ Kidney Problems:	☐ Vision Problems:
☐ Diabetes / Blood Sugar Problems:	☐ Metal Implants:	☐ Other:

FOR MEN: Have you been diagnosed with prostate disease? ☐ Yes ☐ No

FOR WOMEN: Have you been diagnosed with or do you have:
☐ Pelvic inflammatory disease ☐ Endometriosis
☐ Painful periods ☐ Complicated pregnancy/delivery
☐ Other OB/GYN conditions _____

Within the **last year** have you had **any** of the following:

☐ Fever ☐ Constipation ☐ Chest pain / palpitations
☐ Nausea / Vomiting ☐ Urinary difficulty ☐ Loss of balance / falls
☐ Diarrhea ☐ Weight loss / gain ☐ Pain at night

SURGICAL HISTORY: Please list **all** surgeries, including dental and visual: Procedure Name (Date Performed):

_____ (/ /) _____ (/ /) _____ (/ /)
_____ (/ /) _____ (/ /) _____ (/ /)
_____ (/ /) _____ (/ /) _____ (/ /)

MEDICATIONS: Please include **all** current prescriptions. Fill in **all** information.

Name	Dosage	Frequency	Route	Reason Taking

Please list **all** non-prescription medications: (OTC medication, supplements, vitamins, etc.)

_____
_____
_____

FUNCTIONAL STATUS QUESTIONNAIRE: Please, answer the following based how you are doing **today.**
Date of Injury / Onset: _____Cause of Injury / Onset: _____
In the past, have you been treated for this or a similar injury? ☐ Yes ☐ No; If yes, when/where:_____

How often are you experiencing symptoms within one day?
☐ Constantly (76-100%) ☐ Frequently (51-75%) ☐ Occasionally (26-50%) ☐ Intermittently (0-25%)

How are your symptoms changing?
☐ Improving ☐ Not changing ☐ Worsening

How much has your pain interfered with normal **work activities**?
☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

How much has your pain interfered with normal **activities of daily living**?
☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

How would you describe your symptoms? Check all that apply:

☐ Dull	☐ Grinding	☐ Burning	☐ Throbbing
☐ Pulsating	☐ Clicking	☐ Sharp	☐ Unpredictable
☐ Aching	☐ Locking	☐ Heaviness	☐ Other:_____
☐ Stiffness	☐ Cramping	☐ Tingling	_____
☐ Weakness	☐ Stinging	☐ Stabbing	_____

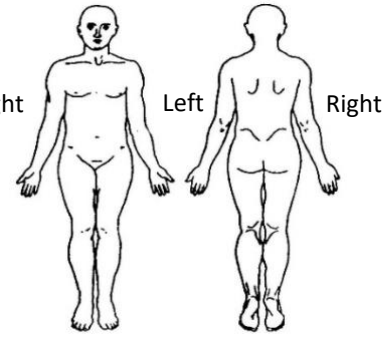
What makes your pain worse? Check all that apply:

☐ Sitting	☐ Squatting	☐ Reading	☐ When still
☐ Rising from sitting	☐ Going up Stairs	☐ Driving	☐ When moving
☐ Standing	☐ Going down Stairs	☐ Lifting	☐ AM
☐ Bending	☐ Lying on back	☐ Pushing	☐ PM
☐ Walking	☐ Lying on side (R / L)	☐ Pulling	☐ Other: _____
☐ Running	☐ Lying on stomach	☐ Overhead activity	_____

What makes your pain better? Check all that apply:

☐ Sitting	☐ Squatting	☐ Reading	☐ When still
☐ Rising from sitting	☐ Going up Stairs	☐ Driving	☐ When moving
☐ Standing	☐ Going down Stairs	☐ Lifting	☐ AM
☐ Bending	☐ Lying on back	☐ Pushing	☐ PM
☐ Walking	☐ Lying on side (R / L)	☐ Pulling	☐ Other: _____
☐ Running	☐ Lying on stomach	☐ Overhead activity	_____

Please mark on the diagram with an **X** where you feel your symptoms. On the scale, mark the intensity of your symptoms.



No Pain ——————————— Worst Possible Pain

Please list your goals for physical therapy (example: Return to hiking without foot pain.)
_____
_____
_____

I voluntarily give my permission to Movement Systems Physical Therapy to provide therapy service and treatment to me. I understand by signing this form, I am authorizing them to treat me for as long as I seek care from Movement Systems Physical Therapy, or until I withdraw my consent in writing.

_____ _____
Signature of Patient or Guardian Date