



17131

PT/OT Patient Intake Form (version 1.5)

www.palladianhealth.com/members



Last name

Grid for last name input

First name

Grid for first name input

PLEASE COMPLETELY FILL IN THE ONE CIRCLE THAT BEST DESCRIBES YOUR ANSWER. (Example: ● )

1. Why are you here today? If there are many reasons, please choose only the most important or most severe one.

- Options for why patient is here today: Neck, Shoulder, Hip, Stroke rehabilitation, etc.

2. When did this problem first begin?

- Options for when problem began: Less than 1 month ago, 1-3 months ago, etc.

Has this problem...

No Yes

3. ... resulted from a work injury (i.e. workers' compensation insurance claim)?

Radio buttons for No/Yes

4. ... resulted from a motor vehicle accident (i.e. no fault insurance claim)?

Radio buttons for No/Yes

5. ... recently been evaluated by a medical doctor?

Radio buttons for No/Yes

Since this problem began, have you noticed...

No Yes

6. ... so much weakness in both your arms that you are unable to lift them?

Radio buttons for No/Yes

7. ... so much weakness in both your legs that you are unable to walk without help?

Radio buttons for No/Yes

8. ... difficulty controlling your bowel or bladder, or have you been unable to urinate?

Radio buttons for No/Yes

9. ... pain in your chest, shortness of breath, or coughing up blood?

Radio buttons for No/Yes

10. ... that one leg felt more warm, more swollen, more red, or more tender than the other?

Radio buttons for No/Yes

Have you recently...

No Yes

11. ... had blurred vision, double vision, dizziness, or fainting?

Radio buttons for No/Yes

12. ... had any type of infection, fever, or chills?

Radio buttons for No/Yes

13. ... had any type of surgery, surgical procedure, or medical procedure?

Radio buttons for No/Yes

14. ... lost a lot of weight without really trying to (i.e without being on a diet)?

Radio buttons for No/Yes

15. ... had any type of accident, fall, or trauma?

Radio buttons for No/Yes

Have you ever...

No Yes

16. ... been diagnosed with cancer?

Radio buttons for No/Yes

17. ... been diagnosed with osteoporosis (i.e. weak, soft, or brittle bones)?

Radio buttons for No/Yes

18. ... been diagnosed with a weakened immune system?

Radio buttons for No/Yes

19. ... used any injected drugs (i.e. non-prescription drugs)?

Radio buttons for No/Yes

20. ... used steroids such as prednisone for more than 4 weeks?

Radio buttons for No/Yes

Is this problem something that ...

No Yes

21. ... you've had before?

Radio buttons for No/Yes

22. ... generally gets worse (i.e more severe or frequent) with movement, activity, or exercise?

Radio buttons for No/Yes

23. ... generally gets better (i.e. less severe or frequent) with rest?

Radio buttons for No/Yes

24. ... was recently examined with diagnostic imaging tests such as x-rays, MRI scan, or CT scan?

Radio buttons for No/Yes

25. ... is also being treated by a health professional other than a physical or occupational therapist?

Radio buttons for No/Yes

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