

PATIENT INTAKE FORM

PATIENT NAME _____

HT _____ WT _____

REFERRAL SOURCE: _____

CONDITIONS (CHECK ALL THAT APPLY)

- | | | |
|---|------|-------|
| <input type="checkbox"/> CARPAL TUNNEL | LEFT | RIGHT |
| <input type="checkbox"/> ARTHRITIS OF HAND | LEFT | RIGHT |
| <input type="checkbox"/> ARTHRITIS OF KNEE | LEFT | RIGHT |
| <input type="checkbox"/> KNEE INSTABILITY | LEFT | RIGHT |
| <input type="checkbox"/> ARTHRITIS OF ANKLE | LEFT | RIGHT |
| <input type="checkbox"/> INSTABILITY OF ANKLE | LEFT | RIGHT |
| <input type="checkbox"/> OA IN HIPS | | |
| <input type="checkbox"/> IMPOTENCE | | |
| <input type="checkbox"/> ABNORMALITY OF GAIT | | |
| <input type="checkbox"/> HEMEPLEGIA | LEFT | RIGHT |

CLINICAL DIAGNOSIS:

- OSTEOARTHRITIS (HANDS, KNEES, HIP, BACK) DEGENETIVE DISC DISEASE
- RHEUMATOID ARTHRITIS SPINAL STENOSIS MULTIPLE SCHELORSIS
- DIABETES W/NEUROPATHY YES NO CONGESTIVE HEALTH FAILURE
- OSTEOARTHRITIS HEART ATTACK OR STROKE AMPUTATIONS

HAVE YOU EVER BEEN DIAGNOSED WITH OSTEOARTHRITIS? IF YES. THEN HANDS, KNEES, HIPS, BACK

HAVE YOU EVER BEEN DIAGNOSED WITH RHEUMTOID ARTHRITIS?

DO YOU HAVE NEUROPATHY? TINGLING IN YOUR HANDS AND FEET. HOW DO YOU CURRENTLY MANAGE IT.

DO YOU HAVE OSTEOPOROSIS?

HAVE YOU EVER BEEN TOLD THAT YOU HAVE ONE OF THE FOLLOWING BACK CONDITIONS: DEGENERATIVE DISC DISEASE, SPINAL STENOIS.

DO YOU HAVE ANY BACK PAIN?
IS IT WORSE FIRST THING IN THE MORNING OR IS IT A CONSTANT PAIN ALL DAY?

HAVE YOU EVER WORN A BACK BRACE? IF SO, WHEN?

HAVE YOU EVER HAD ANY BACK SURGERIES OR SPINAL INJECTIONS?

HAVE YOU BEEN DIAGNOSED WITH CONGESTIVE HEART FAILURE?

HAVE YOU EVER HAD A HEART ATTACK OR STROKE?

DO YOUR KNEES HURT WHEN YOU FIRST GET OUT OF BED IN THE MORNING?

IF YES, HAVE YOU EVER HAD ANY KNEE INJECTIONS OR KNEE SURGERIES. WHAT YEAR.

HAVE YOU EVER WORN A KNEE BRACE? IF SO, WHEN?