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## PHYSICAL THERAPY INTAKE FORM

*Thank you for taking the time to complete this form. Your answers will greatly assist our doctors in providing you the best care possible. All information is confidential.*

Name: _____ Date of Birth: _____

Gender: _____ Sex Assigned at Birth: _____ Preferred Pronouns: _____

Address: _____

Cell Phone: _____ Home Phone: _____

Preferred contact number: ☐ Cell ☐ Home ☐ Other: _____

Email: _____

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Phone: _____

Referring Doctor: _____ Clinic: _____

How did you hear about Sage Cancer Care? _____

Have you had other Physical Therapy visits this calendar year? If so, how many: _____

What do you hope to get out of your visit today?

_____

_____

What are your most important health concerns or symptoms? List in order of importance.

1. _____
2. _____
3. _____
4. _____

What do you believe is the cause of your symptoms: _____

_____

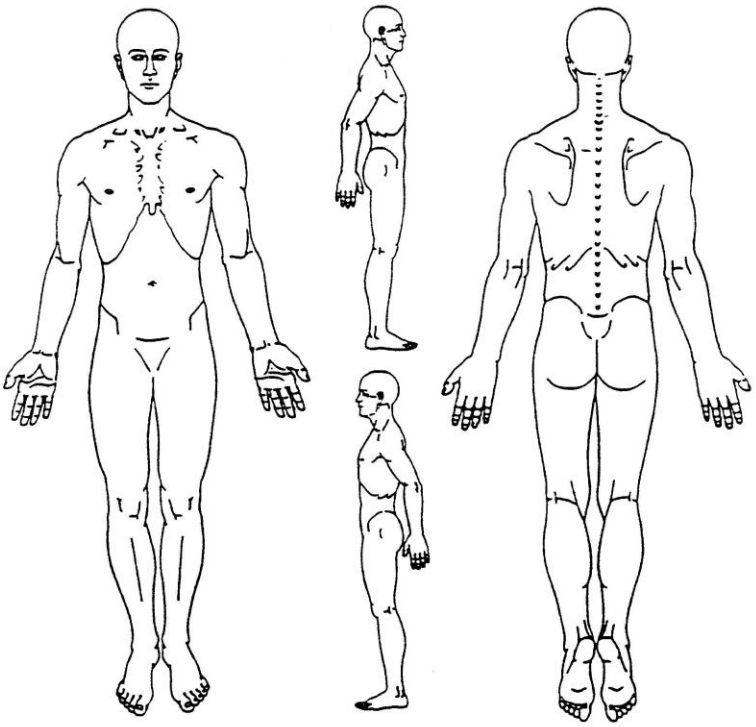
_____

## Current Symptoms

When and how did your symptoms begin:_____

_____

Overall are your symptoms: ☐ Improving ☐ Remaining the same ☐ Worsening



**Mark the location of your symptoms:**

◯ Pain

//// Sharp

△ Aching

↓↓↓ Radiating

*** Numbness/tingling/burning

Swelling

**Pain Intensity:** (rate pain from 0 to 10)

No pain Worst Pain

0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

**Symptoms are worse with:**

☐ Activity ☐ Bending ☐ Sitting ☐ Reaching ☐ Rest ☐ Lying down

☐ Standing ☐ Transitions ☐ Pulling ☐ Pushing ☐ Lifting ☐ Exercise

☐ Work ☐ Dressing ☐ Stress ☐ Coughing/sneezing ☐ Heat

**Symptoms are better with:**

☐ Activity ☐ Rest ☐ Massage ☐ Heat/Ice ☐ Medication ☐ Positioning

☐ No relief ☐ Other: _____

List at least 3 activities that you are currently having challenges with:

(rate their difficulty on a scale of 0 = unable to perform, 10 = able to perform with no difficulty)

1. _____ 0 1 2 3 4 5 6 7 8 9 10

2. _____ 0 1 2 3 4 5 6 7 8 9 10

3. _____ 0 1 2 3 4 5 6 7 8 9 10

## General Health Information

Height: _____Weight: _____ ☐ Right ☐ Left Handed Drink _____ ounces of water per day

Occupation:_____Currently working (hours per week):_____

Primary interests and hobbies: _____

Primary form of exercise, if any: _____How often: _____

**Allergies**

List specific known allergies and describe your reaction.

_____

_____

**Medications and Supplements**

*Please list any prescriptions, OTC medications, or supplements that you currently take.*

| Medication/Supplement Name | Dose | Frequency |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

*(continue on back of page if necessary)*

**Medical History**

Do you have a personal history of any of the following conditions/symptoms (check all):

| | | | |
|---|---|---|---|
| ☐ Autoimmune | ☐ Asthma/COPD | ☐ Heart Disease | ☐ Multiple sclerosis |
| ☐ Anemia | ☐ Intestinal | ☐ Hypertension | ☐ Osteoporosis |
| ☐ Anxiety | ☐ Depression | ☐ Fibromyalgia | ☐ Congestive heart failure |
| ☐ Arthritis | ☐ Diabetes | ☐ Kidney disease | ☐ Hyper/hypothyroid |
| ☐ Stroke | ☐ Blood clot (DVT) | ☐ Dizziness/vertigo | ☐ Currently pregnant |
| ☐ Aortic Aneurysm | ☐ Easy bruising | ☐ Change in vision | ☐ Bowel/bladder changes |
| ☐ Fainting/falls | ☐ Nausea/vomiting | ☐ Difficulty sleeping | ☐ Recent abdominal surgery |
| ☐ Night pain | ☐ Unexplained change in weight | | ☐ Fevers/chills/sweats |

List any other significant medical conditions here:

_____

List any recent diagnostic imaging (Xray, MRI, CT, PET, EMG) including clinic location and date:

_____

## Cancer Diagnosis and Treatment History

*For patients with a cancer diagnosis please complete this section as it applies.*

Date of initial diagnosis: _____ Type of cancer: _____

Current status (check one): ☐ Remission ☐ Active

During or since your treatment did you experience any of the following (check all that apply):

| | | |
|---|---|---|
| ☐ Radiation burns | ☐ Axillary Cording | ☐ Limited range of motion |
| ☐ Infections (cellulitis) | ☐ Lymphedema | ☐ Peripheral neuropathy |
| ☐ Seroma | ☐ Pelvic pain | ☐ Difficulty swallowing |
| ☐ Wounds | ☐ Rashes | ☐ Weakness |

Surgery date: _____

Mastectomy: ☐ Right ☐ Left ☐ Bilateral Lumpectomy: ☐ Right ☐ Left ☐ Bilateral

Reconstruction: ☐ Right ☐ Left ☐ Bilateral Type of Reconstruction:_____

How many lymph nodes removed: Right:_____ Left:_____

Other surgeries:_____

Surgeon: _____ Clinic: _____

Radiation therapy type and date range: _____

Location on body of radiation therapy: _____

Radiation oncologist: _____ Clinic**:** _____

Chemotherapy treatment types and date range: _____

_____

Medical oncologist: _____ Clinic: _____

Additional health care providers (including integrative and alternative) working with you:

Primary care: _____ Phone number: _____

Name: _____ Phone number: _____

Please list any prior cancer/lymphedema related rehabilitation treatment:

| | | |
|---|---|---|
| ☐ Compression garments | ☐ Lymphedema education | ☐ Manual lymphatic drainage |
| ☐ Compression pump | ☐ Compression bandaging | ☐ Exercises |
| ☐ Diuretics | ☐ Kinesiotaping | ☐ Antibiotics |