Westside Dance Physical Therapy - Medical Intake Forms

Name: _____ Date: _____
Diagnosis: _____ MD: _____
Date of Birth: _____Age:_____Height: _____ Weight:_____
Occupation:_____
Emergency contact person: name_____
Phone:_____ Relationship to you_____

History of Present Injury
Date of Injury (if applicable): _____
Describe injury and how it occurred (positions, symptoms, etc.) _____
_____
_____
Place of Occurrence _____
Precipitating factors (eg. not warmed up, cold studio, hard floor) _____
_____
Prior treatment (MD, Chiro, physical therapy, acupuncture, massage) _____
_____
Assistive devices used (cane, crutch, brace, orthotics) _____
Medical tests performed and result (x-ray. MRI, CT scan, bone scan, blood tests, etc)
Please include: when? body region? results?
_____
_____

Personal Health Information:
Are you in good general health?_____
List any surgeries (date and procedure):_____
_____
List prescription and over the counter medications: _____
_____
Do you now or have you ever smoked? (specify packs per day/ how long) _____
Alcohol? (specify)_____ Caffeine? (specify) _____
Do you have a pacemaker, transplanted organ or metal implant? Yes / No
(describe)_____
Have any of the following symptoms occurred with your problem: (circle) numbness, tingling, vomiting, loss of appetite, unexpected weight gain or loss, diarrhea, constipation, blood in stool or urine, inability to hold or release urine, night sweats, fevers, chills, vision changes, fatigue, weakness, headaches, dizziness, fainting spells
Are you currently under the treatment of any doctor other than your referring doctor?
Y/N If yes, who is the doctor and what is being treated?_____
_____
List current fitness activities you do regularly: _____
_____
What are your goals for physical therapy? _____
_____

Past Medical History:
Have you or any immediate family member ever been told you have:

Circle one:	YOU	FAMILY
Cancer	Yes No	Yes No
Diabetes	Yes No	Yes No
Hypoglycemia	Yes No	Yes No
Hypertension or high blood pressure	Yes No	Yes No
Heart disease	Yes No	Yes No
Angina or chest pain	Yes No	Yes No
Shortness of breath	Yes No	Yes No
Stroke	Yes No	Yes No
Kidney disease/stones	Yes No	Yes No
Urinary tract infection	Yes No	Yes No
Allergies	Yes No	Yes No
Asthma, hay fever	Yes No	Yes No
Rheumatic/scarlet fever	Yes No	Yes No
Hepatitis/jaundice	Yes No	Yes No
Cirrhosis/liver disease	Yes No	Yes No
Polio	Yes No	Yes No
Chronic bronchitis	Yes No	Yes No
Pneumonia	Yes No	Yes No
Emphysema	Yes No	Yes No
Migraine headaches	Yes No	Yes No
Anemia	Yes No	Yes No
Ulcers/stomach problems	Yes No	Yes No
Arthritis/gout	Yes No	Yes No
AIDS/HIV-positive	Yes No	Yes No
Hemophilia/slow healing	Yes No	Yes No
Guillain-Barre syndrome	Yes No	Yes No
Epilepsy	Yes No	Yes No
Thyroid problems	Yes No	Yes No
Multiple sclerosis	Yes No	Yes No
Tuberculosis	Yes No	Yes No
Fibromyalgia/myofascial Pain syndrome	Yes No	Yes No
Lyme Disease	Yes No	Yes No
Lymph node removal	Yes No	Yes No
Alcoholism	Yes No	Yes No
Seizures	Yes No	Yes No
Osteoarthritis		
Other (please describe)	Yes No	Yes No

Special Questions for Dancers (for dance professionals or those with dance injuries)
Age began dancing _____ Type of dance you do: _____
Age you began pointe work: _____
Formal dance training: school_____ number of years _____
school_____ number of years _____
Present dance training and number of classes/week:_____
_____
Are you performing now? _____ Name of Company: _____
Type of shoes worn: _____ Type of floor surface you dance on: _____
Number of years you have been dancing as a professional: _____
List major injuries of illnesses throughout your career including:

Date	Type of injury	Whom seen	Course of Treatment	Recovery

Special Questions for Women

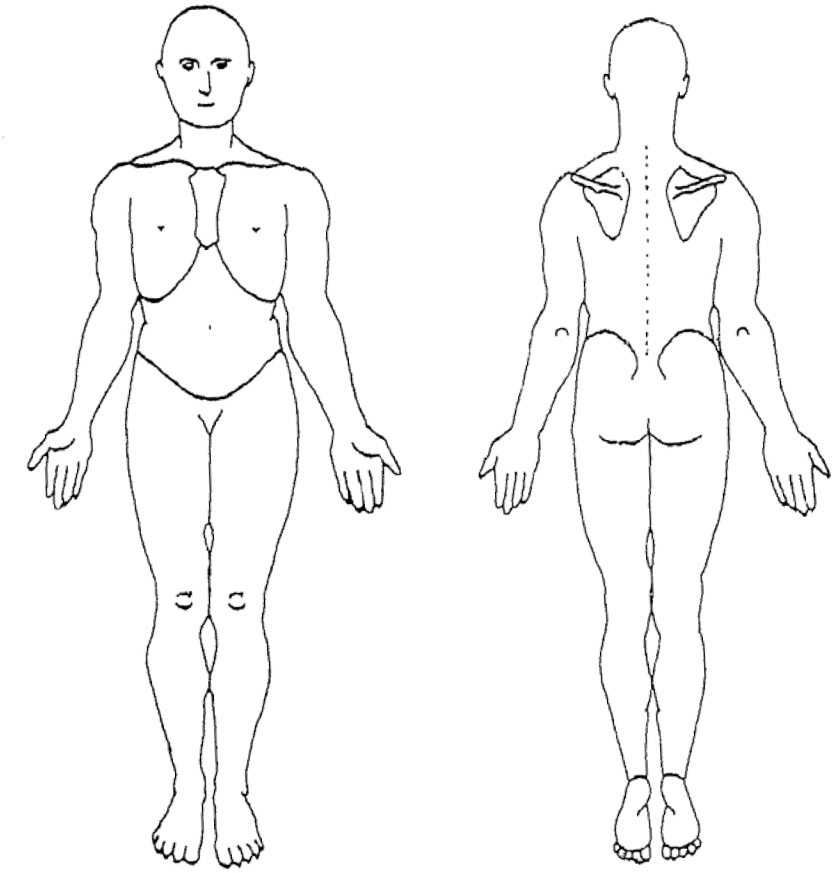
1. At what age did you start menstruating?_____
2. Are your cycles regular? _____yes/no_____
   Explain:_____
3. Are the symptoms of your CURRENT INJURY associated with your menstrual cycle either around the 14th day (ovulation) or at the onset of menses?__Yes/No
4. Do you notice a change in flexibility at either of these times? Yes/No_____
5. Circle any premenstrual symptoms: water retention, mood swings, headaches, food cravings, tender breasts, other _____
6. What type of birth control do you use?_____
7. Pregnancies:_____ Vaginal births_____ Cesarean section_____
   Episeotomy_____ Numbness in pelvic area?_____
   Problems related to pregnancy_____
8. Do you currently experience leakage of unrine? Yes/No Circle if it occurs with Jumping, Coughing, Sneezing, Laughing, Intercourse, When putting key in door
8. Do you have any pelvic pain? Yes/No What activity brings it on?_____
9. Circle if you have had or have any of the following: Retroverted uterus, Fibroids or tumors, Endometriosis, Ovarian cyst, Pelvic inflammatory disease, Osteopenia, Osteoporosis, Diabetes,
10. Have you gone through menopause Yes/No or perimenopause Yes/No
11. Are you taking any medications, herbs or supplements for hormone replacement? Yes/No If yes, please list_____

Name: _____Date: _____

1. BODY DIAGRAM
Indicate your symptoms on the body diagrams using the symbols in the key below:
Key:

/////// Stabbing
XXX Burning
OOO Pins and Needles
++++ Numbness
AAAA Ache

If description is not found, circle area and write in what it feels like.



2. PAIN SCALE

On the line below, please make a line where you think your pain level is at when at rest (#1) and with activity (#2):

0 = no pain or symptoms
10 = the worst pain you've ever had

#1 REST: |-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|
0 1 2 3 4 5 6 7 8 9 10

#2 ACTIVITY: |-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|
0 1 2 3 4 5 6 7 8 9 10