HONORHEALTH®

Patient Label

OUTPATIENT THERAPY PATIENT INTAKE FORM

Name: ______________________________ Date of Birth: __________ Today's Date: __________

Home Phone: (_____) ______ - ________ Cell Phone: (_____) ______ - ________

Email Address: ____________________ @ __________ Best way to contact: ☐ Home ☐ Cell ☐ Email

Emergency Contact: ________________________ Phone Number: (_____) ______ - ________

How did you choose HonorHealth Outpatient Therapy? ☐ Physician Recommended

☐ Had been a Patient Previously ☐ Friend Recommended ☐ Phonebook/Internet ☐ __________

Referring Physician: ____________________ Primary Care Physician: ____________________

Chief Complaint: ____

Date of Injury or Onset of Symptoms: ____

How did you get injured? ____

Have you had this injury or injured this body part before? ☐ Yes ☐ No

If Yes, when and how: ____

Have you had Physical Therapy/Occupational/Speech Therapy Before? ☐ Yes ☐ No

If Yes, when and for what: ____

Did you have Surgery? ☐ Yes ☐ No If yes, date/type of surgery: ____________________

Do you have a follow-up appointment with your physician? ☐ Yes ☐ No Date: __________

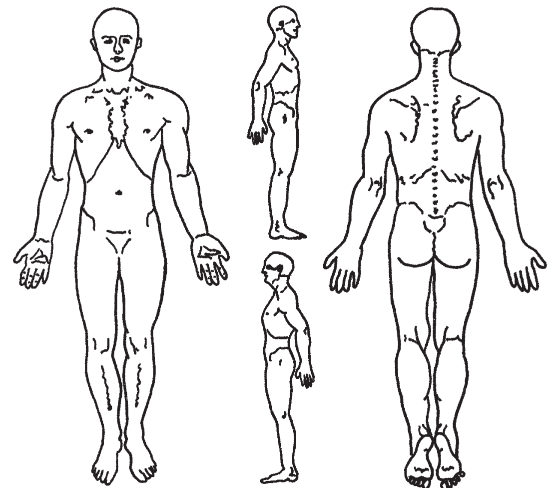
Have you had: ☐ X-rays ☐ CT Scan ☐ MRI ☐ Other __________ Result: __________

Please rate your General Health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you experience pain? ☐ Yes ☐ No

How long does the pain last? _____ hours/day _____ days/week

Please indicate on the drawing where you are experiencing pain:



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On a scale from 0 (no pain) to 10 (the worst pain you could imagine), what is your pain:

Now:	0	1	2	3	4	5	6	7	8	9	10
Worst:	0	1	2	3	4	5	6	7	8	9	10
Best:	0	1	2	3	4	5	6	7	8	9	10

What increases the pain? ______________________________

What decreases the pain? ______________________________

Describe your pain (e.g. ache, sharp, constant, ...): ______________________________

Are you currently working? ☐ Yes ☐ No ☐ Retired If no, last day worked: ______________

Occupation: ______________________________

If this is a work injury, are you on: ☐ Full Duty ☐ Light Duty ☐ Off Duty

What recreational activities do you do on a regular basis (e.g., walking, basketball, weightlifting, swimming, ...)?

____

How many days per week are you physically active? ☐ 0 ☐ 1-2 ☐ 3-5 ☐ 6-7

Please **List 3** important activities that you are unable to do or that you are having difficulty doing as a result of your problem with zero (0) being unable to perform the activity and ten (10) being able to perform the activity at your pre-injury level.

Activities:	Unable										Normal
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

What are your goals for therapy? ______________________________

____

Patient's Signature: ______________________________ Date: ______________