University of Connecticut
Health Center
John Dempsey Hospital
Department of
Rehabilitation Services

(Patient Identification)

SUBJECTIVE INTAKE FORM

Date: _____ Age: _____

Are you currently receiving? ☐ ***HOME CARE*** ☐ ***Chiropractic Care***
If you check one of the above boxes, please stop filling out this form and consult with a Patient Services Representative.

Organization Name: _____ ***Date Services Started:*** _____

TELL US ABOUT YOUR INJURY OR SYMPTOMS

What is your primary complaint (why you are here): _____

_____

When did your symptoms start: _____

How did this injury/illness occur: _____

_____

How much do your symptoms interfere with your usual daily activities?

☐ Not at all ☐ A little ☐ Moderately ☐ Quite a bit ☐ Extremely

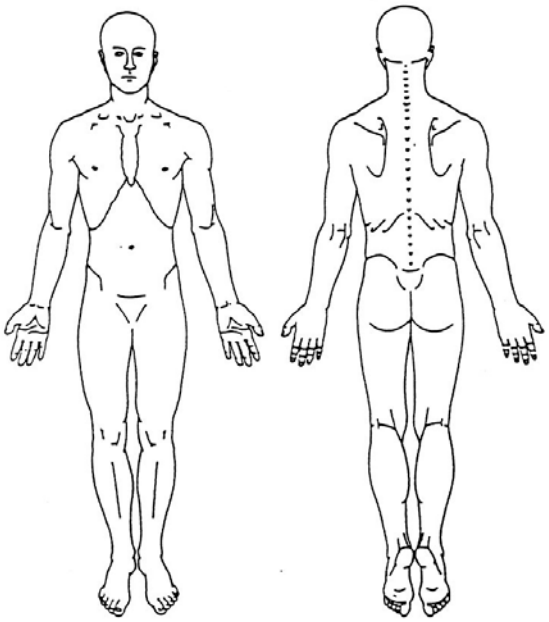
Pain Scale: (0-10) Present : _____ (0-10) Worst _____ (0-10) Best: _____

Date of next doctor's appt.:_____

Have you received therapy for this condition before? ☐ Yes ☐ No

Explain: _____

_____



* Place X's for any areas of tingling or numbness
* Shade in area of your pain

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DIAGNOSTIC IMAGING Have you had a recent Imaging test for your injury or symptoms:

☐ None ☐ X-Rays ☐ CT Scan ☐ MRI ☐ LAB TESTS

Results:_____

_____

TELL US ABOUT YOU

LIVING ENVIRONMENT: I live: ☐ Alone ☐ With family, spouse, partner ☐ Other:_____

Do you have stairs to get into your home? ☐ YES How many? _____ ☐ NO

Do your stairs have rails? ☐ YES ☐ NO

Do you have stairs inside your home? ☐ YES How many? _____ ☐ NO

Do your stairs have rails? ☐ YES ☐ NO

WORK ENVIRONMENT: Are you presently working? ☐YES ☐NO

What is your job/occupation? _____

What kinds of activities do you perform at work? _____

Do you use any special supports (brace, corset, cushions, etc.)? ☐YES ☐ NO

Explain: _____

LEARNING STYLES: What is your preferred method of learning (check all that applies)?

☐ Verbal ☐ Visual ☐ Demonstration

Do you have any barriers to learning? ☐YES ☐ NO If yes, please explain: _____

_____

PRIOR LEVEL OF FUNCTION

Activities of Daily Living (bathing, dressing, meal prep): ☐ Independent

☐ Independent with extra time ☐ Requires Assistance ☐ Unable to Perform

Other: _____

Work Activities: ☐ Independent ☐ Independent with extra time ☐ Requires Assistance

☐ Unable to Perform

Other: _____

Recreational Activities:

Work Activities: ☐ Independent ☐ Independent with extra time ☐ Requires Assistance

☐ Unable to Perform

Other: _____

Do you use an assistive device? ☐ YES ☐ NO Explain: _____

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TELL US ABOUT YOUR MEDICAL HISTORY:

Medical History	Yes	No		Yes	No
CARDIAC			**MUSCULOSKELETAL**		
Angina/Chest Pain			Osteoporosis		
Heart Attack			Fractures/Broken bones		
Heart Disease			Rheumatoid Arthritis		
Heart Palpitations			Osteoarthritis		
High Cholesterol			Metal Implants		
High Blood Pressure			**SKIN**		
Pacemaker			Psoriasis		
RESPIRATORY			Skin Abnormalities		
COPD			Rash		
Asthma			Non Healing Wounds		
Tuberculosis			**ENDOCRINE/RENAL**		
Other			Diabetes		
NEUROLOGICAL CONDITIONS			Kidney Stones/Disease		
Stroke			Liver/Gallbladder problems		
Multiple Sclerosis			Hernia		
Seizures/epilepsy			Thyroid problems		
Parkinsons			**EMOTIONAL**		
Head injury			Anxiety/Panic Attacks		
Swallowing Issues			Depression		
Muscular Dystrophy			Eating Disorders		
Headaches			**OTHER**		
Memory Loss			Ulcers/Stomach Disease		
Dizziness/Fainting			Bleeding Disorder		
Ringing in your ears			Chemical Dependency		
Visual Changes/Double Vision			Hepatitis A/B/C		
CANCER			HIV		
Breast			Bowel/Bladder problems		
Prostate			Night pain		
Blood			Nausea/Vomiting		
Lymphatic system			Unexpected weight loss/gain		

Other: _____

_____

_____

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MEDICAL HISTORY (Continued):
Please explain any of the checked items:

_____
_____
_____
_____
_____

For Men: Have you been diagnosed with prostate disease? ☐Yes ☐ No

For Women: Are you pregnant or do you think that you might be pregnant? ☐Yes ☐ No

ALLERGIES ☐ **No Known Allergies**

☐ Environmental List: _____

☐ Medicine List: _____

MEDICATIONS

Please list any medications you are presently taking or have recently stopped: _____

_____

_____

SURGICAL HISTORY:
Have you ever had surgery? YES/NO If yes, please list, with approximate dates:

_____
_____
_____
_____
_____

Is there anything else you think is important about your condition that that we haven't covered?

_____
_____
_____

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TELL US ABOUT YOUR GENERAL HEALTH

Do you smoke or chew tobacco? ☐ YES How much? _____For how long? _____ ☐ NO

Have you had any unexplained weight gain or loss in the last month? ☐ YES ☐ NO

Do you have difficulty with: Hearing: ☐ YES ☐ NO Do you wear Hearing Aids? ☐ YES ☐ NO

Vision: ☐ YES ☐ NO Do you wear Glasses/Contacts ☐ YES ☐ NO

What type of activities, exercise, and/or sports do you participate in? _____

_____

Do you have trouble sleeping at night? ☐ YES ☐ NO If yes, explain: _____

_____

DO YOU HAVE A HISTORY OF FALLS ☐ YES (check what best applies) ☐ NO

☐ I have fallen recently (within the past month)

☐ I fall frequently (more than twice over the past 6 months)

☐ I have fallen in the past year

☐ I have almost fallen due to losing my balance

☐ **The Fall Screen was performed and the patient's Fall Risk was appropriately assessed.**

The above information has been reviewed and discussed by the patient and the therapist.

_____ _____

Patient Signature Date / Time

_____ _____

Therapist Signature Date / Time