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

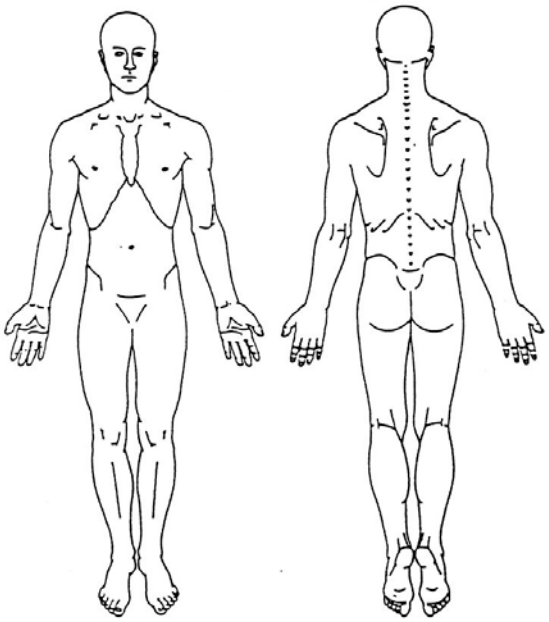
Pain Scale: (0-10) Present : _____ (0-10) Worst _____ (0-10) Best: _____

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

HCH2354

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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