Sage CANCER CARE

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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: _____ Gender: _____ Date of Birth: _____

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: _____

_____

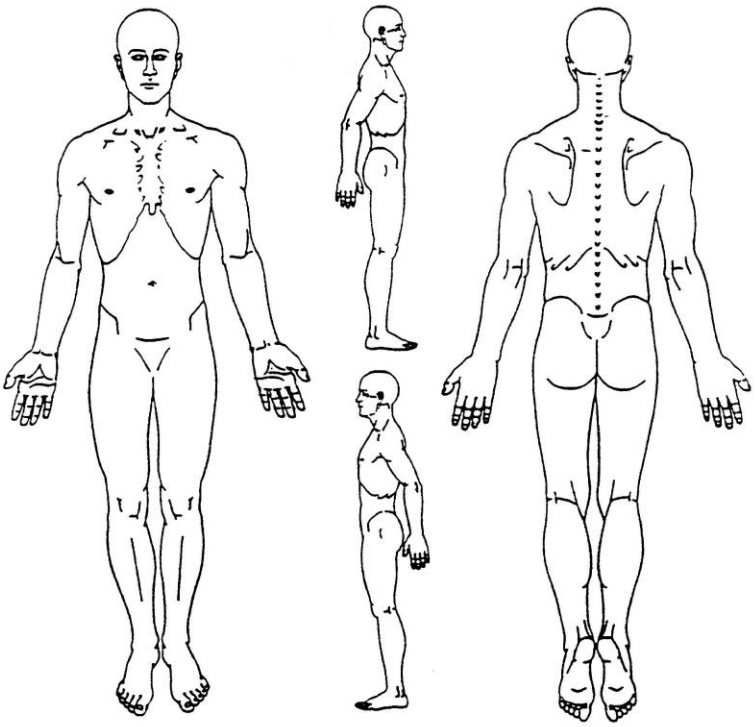
_____

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