



1836 NE 7th Avenue, Suite 205 | Portland, OR 97212

Phone: 503-206-6218 | Fax: 888-972-1720

sagecancer.com

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. _____

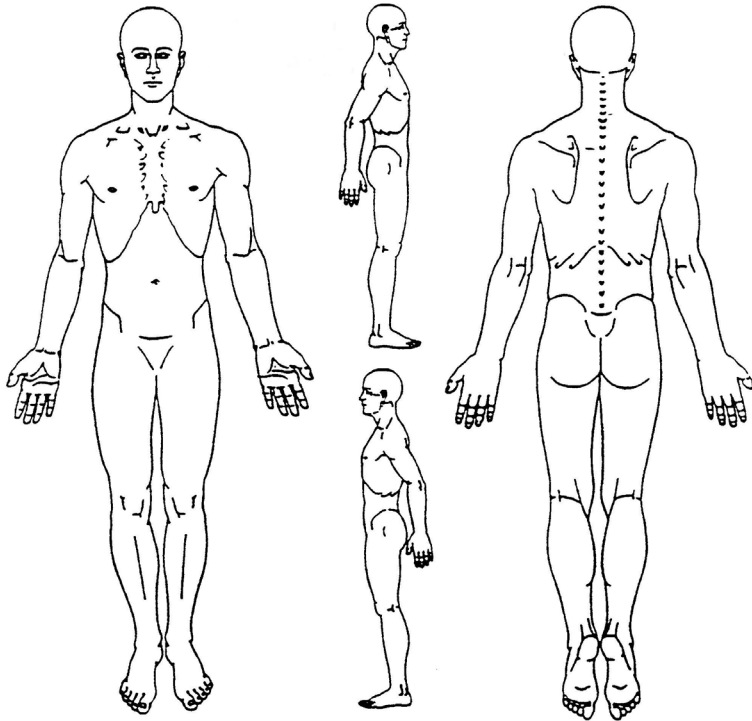
4. _____

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):

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Autoimmune | <input type="checkbox"/> Asthma/COPD | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Multiple sclerosis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Intestinal | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Depression | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Congestive heart failure |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Hyper/hypothyroid |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Blood clot (DVT) | <input type="checkbox"/> Dizziness/vertigo | <input type="checkbox"/> Currently pregnant |
| <input type="checkbox"/> Aortic Aneurysm | <input type="checkbox"/> Easy bruising | <input type="checkbox"/> Change in vision | <input type="checkbox"/> Bowel/bladder changes |
| <input type="checkbox"/> Fainting/falls | <input type="checkbox"/> Nausea/vomiting | <input type="checkbox"/> Difficulty sleeping | <input type="checkbox"/> Recent abdominal surgery |
| <input type="checkbox"/> Night pain | <input type="checkbox"/> Unexplained change in weight | <input type="checkbox"/> 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):

- | | | |
|--|---|--|
| <input type="checkbox"/> Radiation burns | <input type="checkbox"/> Axillary Cording | <input type="checkbox"/> Limited range of motion |
| <input type="checkbox"/> Infections (cellulitis) | <input type="checkbox"/> Lymphedema | <input type="checkbox"/> Peripheral neuropathy |
| <input type="checkbox"/> Seroma | <input type="checkbox"/> Pelvic pain | <input type="checkbox"/> Difficulty swallowing |
| <input type="checkbox"/> Wounds | <input type="checkbox"/> Rashes | <input type="checkbox"/> 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:

- | | | |
|---|--|--|
| <input type="checkbox"/> Compression garments | <input type="checkbox"/> Lymphedema education | <input type="checkbox"/> Manual lymphatic drainage |
| <input type="checkbox"/> Compression pump | <input type="checkbox"/> Compression bandaging | <input type="checkbox"/> Exercises |
| <input type="checkbox"/> Diuretics | <input type="checkbox"/> Kinesiotaping | <input type="checkbox"/> Antibiotics |
-



Consent to Physical Therapy Evaluation and Treatment

Physical therapy is a patient care service that is provided in order to manage a wide variety of conditions. Services are provided to individuals of all ages regardless of gender, color, ethnicity, creed, national origin, or disability.

The purpose of physical therapy is to treat disease, injury and disability by examination, evaluation, diagnosis, prognosis and intervention by use of rehabilitative procedures, mobilization, massage, exercises, and physical agents to aid the patient in achieving their maximum potential within their capabilities and to accelerate convalescence and reduce the length of functional recovery. All procedures will be thoroughly explained to you before you are asked to perform them.

Response to physical therapy intervention varies from person to person; hence, it is not possible to accurately predict your response to a specific modality, procedure, or exercise protocol. Sage Cancer Care, Inc does not guarantee what your reaction will be to a specific treatment, nor does it guarantee that the treatment will help resolve the condition that you are seeking treatment for. Furthermore, there is a possibility that the physical therapy treatment may result in aggravation of existing symptoms and may cause pain or injury. It is your right to decline any part of your treatment at any time before or during treatment, should you feel any discomfort or pain or have other unresolved concerns. It is your right to ask your physical therapist about the treatment they have planned based on your individual history, physical therapy diagnosis, symptoms, and examination results. Consequently, it is your right to discuss the potential risks and benefits involved in your treatment.

I hereby consent to the evaluation and treatment of my condition by a licensed physical therapist employed by Sage Cancer Care, Inc. The physical therapist will explain the nature and purposes of these procedures, evaluation, and course of treatment. The physical therapist will inform me of expected benefits and complications, and any discomforts, and risk that may arise, as well as alternatives to the proposed treatment and the risk and consequences of no treatment.

I have read this consent form and understand the risks involved in physical therapy and agree to fully cooperate, participate in all physical therapy procedures, and comply with the established plan of care. I hereby consent to the evaluation and treatment of my condition by a licensed physical therapist employed by Sage Cancer Care, Inc. I authorize the release of my medical information to appropriate third parties.

Physical Therapist: Elsa Mitchell, DPT, CLT-LANA, NPI: 1568773380

Signature of Patient: _____

Date: _____