PHYSICIANS' CLINIC
of Iowa, P.C.

PHYSICAL MEDICINE & REHABILITATION
SPINE & MSK PATIENT INTAKE FORM

Today's Date _____ Name _____ Date of Birth _____

Occupation _____ Hand Dominance: ☐ Left ☐ Right ☐ Ambidextrous

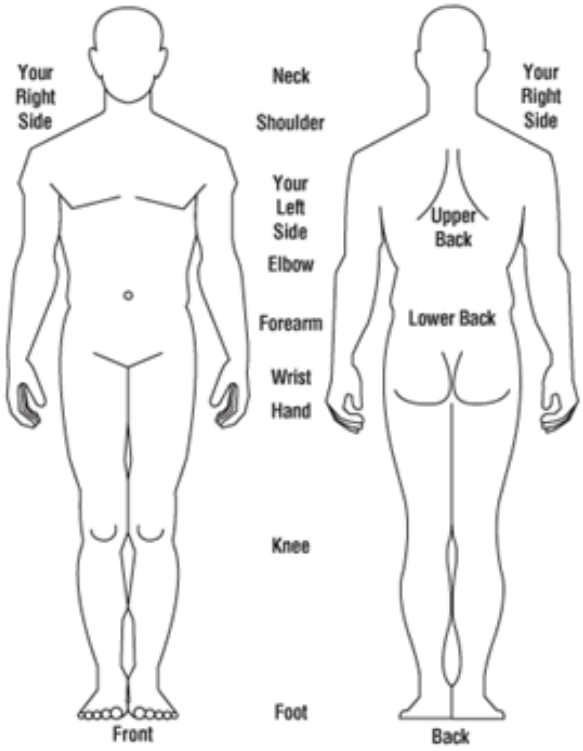
Who referred you? ☐ Doctor (name) _____ ☐ Therapist (name) _____ ☐ Self ☐ Attorney

Reason for your visit (please be specific) _____

_____

_____

Please indicate on the diagram below where you are experiencing pain, numbness, and/or tingling. Use the following symbol on the diagram:
Pain=1, Numbness =0, Tingling =X



Quality of Pain: ☐ Sharp ☐ Stabbing ☐ Dull ☐ Aching ☐ Throbbing
☐ Burning ☐ Shooting ☐ Other _____

Timing? ☐ Constant ☐ Comes and Goes

Does it wake you at night? ☐ Yes ☐ No

What makes your symptoms worse? (check all that apply)

☐ Standing ☐ Walking ☐ Lifting ☐ Reaching ☐ Twisting ☐ Exercise
☐ Lying Flat ☐ Bending ☐ Stairs ☐ Squatting ☐ Kneeling ☐ Sitting
☐ Coughing ☐ Sneezing ☐ Stress
☐ Other _____

What makes your symptoms better? ☐ Rest ☐ Ice ☐ Heat ☐ Medications
☐ Other _____

Since your problem started, is it getting: ☐ Better ☐ Worse ☐ Unchanged

Please indicate the highest and lowest levels of pain:

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

No Pain ⟷ Moderate Pain ⟷ Severe Pain

What treatments have you tried? ☐ Physical Therapy ☐ Bracing ☐ Injections ☐ Cane/walker/wheelchair

What tests have you had? ☐ X-rays ☐ MRI ☐ ICT ☐ Nerve Test (EMG)

Where? ☐ PCI ☐ Mercy ☐ St. Luke's ☐ RCI

Have you had surgery for this problem? ☐ Yes ☐ No If yes, surgeon's name and where is was performed: _____

_____