Patient Name:_____

HOPS Therapy Services

Patient Intake Sheet

305 Center Street, Seville, Ohio 44273
(330)769-4677 Voice/ (330) 769-4644 Fax

What is your main complaint, or reason for coming to HOPS Therapy Service?

_____

_____

Personal/Social History

With whom do you live? Please check all that apply.

☐ Alone ☐ Spouse ☐ Other relatives
☐ Child (no spouse) ☐ Spouse and others ☐ Group Setting
☐ Personal Care attendant ☐ Other:_____

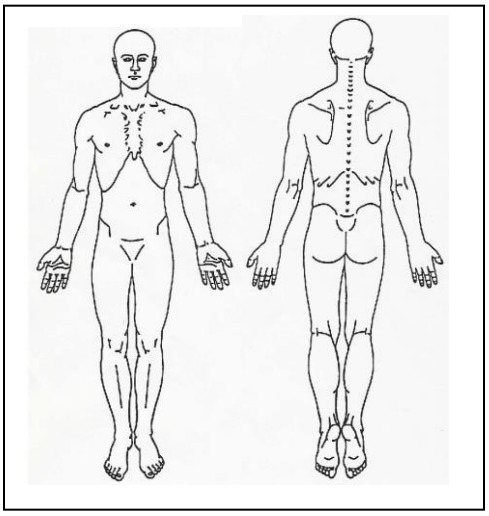
What's the best way to provide you with instruction (Check best answer)
☐ Picture ☐ Verbal ☐ Written ☐ Education to caregiver

Do you smoke? ☐ Yes ☐ No
If yes how many packs per day: _____

Do you drink? ☐ Yes ☐ No
If yes how many days per week do you drink? _____
How many alcoholic beverages do you consume per day on average? _____

Do you exercise beyond normal everyday activities? ☐ Yes ☐ No
If yes please describe:

Please mark where you have pain/discomfort below?



Are there any religious, cultural beliefs or wishes that might affect your care?

Have you had any Physical/Occupational Therapy during the current calendar year? _____
Have you had Physical/Occupational Therapy for the same condition for which you are here today? _____

Employment/Work – please check all that apply *Are you presently working? ☐ Yes ☐ No (if no skip to diagnostic testing)*

☐ Full-time ☐ Student ☐ Part Time ☐ Retired
☐ Unemployed ☐ Disabled ☐ Home Maker ☐ Occupation/ Other:_____

Employer: _____ Work Phone: _____

Does your job require:

- Heavy Lifting? ☐ Yes ☐ No If so, how much are you expected to lift?
- Overhead Lifting? ☐ Yes ☐ No If so, how much are you expected to lift overhead?
- Prolonged Standing? ☐ Yes ☐ No If so, how long?
- Climbing? ☐ Yes ☐ No If so, how high and how much?
- Sitting? ☐ Yes ☐ No If so, for how long?
- Repetitive movements? ☐ Yes ☐ No If so, what motions and how often?

What is the most physically taxing part of you job? _____

Diagnostic Testing Section:

Please check all diagnostic tests you have had in the last year:

☐ Arthroscopy ☐ CT Scan ☐ MRI ☐ Urine Tests
☐ Biopsy ☐ Doppler Ultrasound ☐ Myelogram ☐ X-rays
☐ Blood Tests ☐ EMG ☐ Nerve conduction test ☐ Other:_____
☐ Bone Scan ☐ EKG ☐ Stress Test _____

Results: _____

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Past Medical History

☐ Anemia	☐ Diabetes/High Blood Sugar	☐ Osteoporosis/Osteopenia
☐ Arthritis	☐ Head Injury	☐ Parkinson Disease
☐ Asthma	☐ Heart Problems	☐ Repeated Infections
☐ Blood Disorders	☐ High Blood Pressure	☐ Rheumatoid Arthritis
☐ Broken Bones/Fractures	☐ Infectious Disease	☐ Seizures/Epilepsy
☐ Cancer	☐ Kidney Problems/Hepatitis	☐ Skin Diseases
☐ Chemical Dependency	☐ Low Blood Sugar	☐ Stroke
☐ Circulation/Vascular problems	☐ Lung Problems	☐ Thyroid Problems
☐ Developmental/Growth problems	☐ Multiple Sclerosis	☐ Ulcers/Stomach Problems
☐ Depression	☐ Muscular Dystrophy	☐ Other:_____

Within the past year, have you had any of the following?

☐ Unintentional Weight loss or gain	☐ Breast pain/tenderness	☐ Change in menstruation
☐ Pain at night	☐ Cough	☐ Headaches
☐ Fever/Chills	☐ Shortness of breath	☐ Memory impairments/changes
☐ Night Sweats	☐ Chest pain/Heart palpitations	☐ Coordination problems
☐ Skin problems or changes	☐ Swelling/Fluid accumulation	☐ Weakness in arms or legs
☐ Vision problems	☐ Appetite changes	☐ Difficulty walking
☐ Hearing problems	☐ Nausea or Vomiting	☐ Loss of balance
☐ Hoarseness/Voice changes	☐ Urinary problems/changes	☐ Dizziness/Blackouts
☐ Sore throat	☐ Bowel problems (diarrhea/constipation)	☐ Depression/Mood changes
☐ Difficulty swallowing	☐ Abdominal pain	☐ Anxiety
☐ Indigestion/Heartburn	☐ Testicular pain/swelling Breast pain/tenderness	☐ Other:_____ _____

Have you fallen in the past 12 months: Yes No

Please list all surgeries:

_____
_____
_____
_____

Do you have METAL anywhere in your body (other than teeth), such as pins/plates, pacemaker, stints? etc? ☐ Yes ☐ No
Describe: _____

Please list all **medications** you are currently taking:

_____
_____
_____
_____
_____
_____

Thank you for taking the time to complete this form. All information will remain confidential and will be used to develop your therapy treatment plan.