NISMAT
Nicholas Institute of Sports Medicine and Athletic Trauma

Patient Intake Form

Northwell Health℠

Patient Name: _____ Date: ____/____/____
First Last

E-Mail Address: _____

Preferred Contact Phone Number: _____ ☐ Home ☐ Cell ☐ Work

Weight: _____ Height: _____ ☐ Right-handed ☐ Left-handed

Referring doctor: _____ Follow-up with doctor: ____/____/____

With whom do you live? _____ Is your home handicap accessible? ☐ Yes ☐ No

How many flights of stairs at home? _____ Do you use a handrail? ☐ Yes ☐ No

Do you use: ☐ Cane ☐ Crutches ☐ Walker ☐ Wheelchair ☐ Sling ☐ Brace ☐ Other: _____

- Past Medical History (Check all that apply):

☐ Arthritis
☐ Broken bones/fractures
☐ Ligament injury
☐ Muscle/tendon injury
☐ Cartilage/meniscus injury
☐ Osteoporosis/Osteopenia
☐ Joint dislocation
☐ Connective tissue disorder
☐ Blood disorder
☐ Circulation/vascular problem
☐ Neuropathy/neuralgia
☐ Heart problems
☐ High blood pressure
☐ Lung problem
☐ Stroke
☐ Diabetes
☐ Head injury
☐ Other: _____
☐ Parkinson's disease
☐ Seizures/epilepsy
☐ Thyroid problem
☐ Cancer
☐ Kidney problem
☐ Falls/balance problem
☐ Skin disease/infection
☐ Depression

- Past Surgical History and Hospital Admissions:

Reason for admission/surgery	Month/Year		
_____	____/____	_____	____/____
_____	____/____	_____	____/____
_____	____/____	_____	____/____

All medications and supplements (prescription & over-the-counter):

_____

_____

_____

- PT History

Have you received PT in the past? ☐ No ☐ Yes - for what condition? _____

Was PT helpful? ☐ No ☐ Yes

- Social/Health Habits

Do you currently smoke tobacco? ☐ No ☐ Yes - cigarettes/cigars/pipe amount per day: _____

Smoked in the past? ☐ No ☐ Yes - year quit: _____

Alcohol consumption - number of drinks per week: _____

Do you exercise? ☐ No ☐ Yes - describe: _____

How much and how often? _____

Recreational/social activities - describe: _____

- Employment Status

☐ Employed ☐ Unemployed ☐ Disabled ☐ Retired How many hours worked per week: _____

Occupation: _____ Employer: _____

- General Health Status

Please rate your health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Have you had any major life changes in the past year? (e.g., new baby, job change, death in family)

☐ No ☐ Yes - describe: _____

- Chief Complaint

Describe the problem(s) for which you seek physical therapy:

_____

Have you ever had the problem(s) before? ☐ No ☐ Yes - How was it treated? _____

Have you received any other treatments for this condition? (e.g., injections, medications, acupuncture)

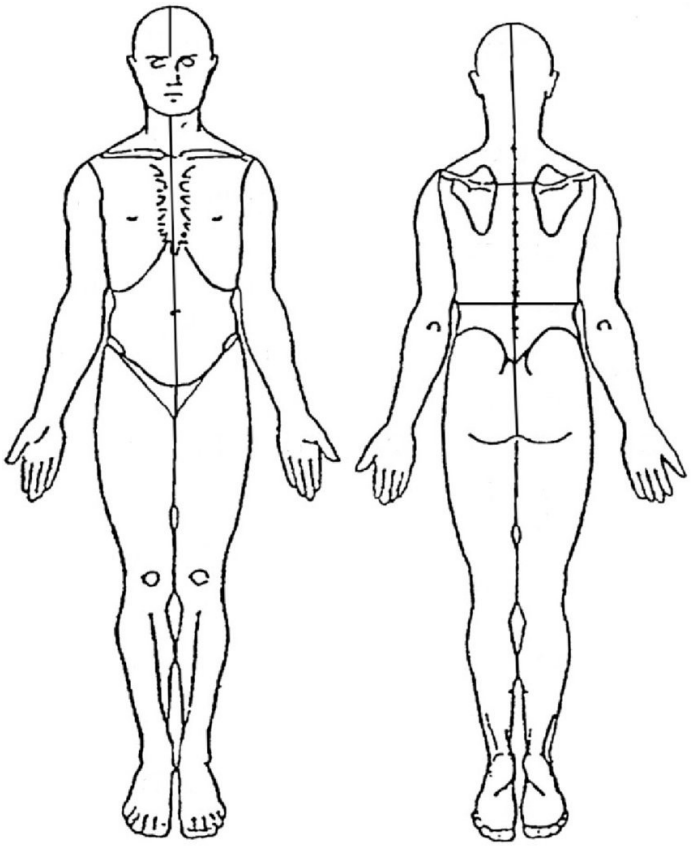
☐ No ☐ Yes - describe: _____ Improvement? ☐ No ☐ Yes

- What are your goals for physical therapy?

_____

_____

On the diagram below, please indicate the location(s) of your current pain.



On the scale below, please circle the number closest to your level of pain.

Pain at Rest:										
0	1	2	3	4	5	6	7	8	9	10
No Pain										Worst Pain
Pain with Activity (walking, sitting, dressing, bathing):										
0	1	2	3	4	5	6	7	8	9	10
No Pain										Worst Pain
Pain with strenuous activities (lifting, squatting, sports activities):										
0	1	2	3	4	5	6	7	8	9	10
No Pain										Worst Pain

Name: _____ DOB: _____