STM Patient Intake Form

DATE: _____

Patient Information

Patient Name	Last	First	MI

O Female
O Male

Patient Date of Birth: Month / Day / Year

Patient Address	Street	City	State	Zip Code

Patient Insurance	Member ID #

Referring Physician	Discipline (PT/OT)

Date of Referral: Month / Day / Year

Type of Injury

Date of Injury: Month / Day / Year

Type of Surgery

Date of Surgery: Month / Day / Year

List of Medications:

Other Medical Problems:

1. Average Pain Intensity

Past 24 hrs: No Pain ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Extreme Pain

Last Week: No Pain ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Extreme Pain

2. Briefly describe your symptoms:

3. How did your symptoms start:

4. How often do you experience your symptoms

① Constantly ② Frequently ③ Occasionally ④ Intermittently

5. How much does it interfere with your daily activities

① Not at all ② A little Bit ③ Moderately ④ Quite a bit ⑤ Extremely

6. Functional Limitations:

7. Indicate where you feel Pain or other Symptoms: