Physical Therapy Center of Ocean Springs

FCE INTAKE SHEET

DATE:_____ NAME:_____ CHART #_____

DATE OF INJURY: _____ HOW LONG AT JOB? _____

LAST DAY WORKED:_____ CURRENTLY WORKING FULL OR LIGHT DUTY? Y/N

LEFT OR RIGHT HANDED? R/L AGE:_____

BRIEFLY DESCRIBE JOB DUTIES_____
_____
_____
BRIEFLY DESCRIBE HOW THE INJURY OCCURRED:_____
_____
_____

WEIGHT LOADS REQUIRED TO LIFT ON YOUR JOB:
FROM FLOOR: AVERAGE:_____ HEAVIEST:_____
FROM WAIT LEVEL: AVERAGE:_____ HEAVIEST:_____
ABOVE SHOULDER/HEAD: AVERAGE:_____ HEAVIEST:_____

SURGERY? YES/NO DATE:_____ TYPE/AREA:_____

DO YOU HAVE MD ISSUED WORK RESTRICTINS? YES/NO
IF YES, PLEASE LIST:_____

PAIN SCALE: (PLEASE CIRCLE ONE) NO PAIN 1 2 3 4 5 6 7 8 9 10 BAD PAIN
1=MILD 2=DISCOMFORTING 3=DISTRESSING 4=HORRIBLE 5=EXCRUTIATING

DOES YOUR JOB REQUIRE THE FOLLOWING? (Please check all that apply)
_____SITTING HOW LONG?_____
_____STANDING HOW LONG?_____
_____CKIMBING STAIRS/LADDERS
_____WALKING IF GREATER THAN 30 MINUTES WITHOUT NO REST
_____LOW LEVEL ACTIVITY (SQUAT, CRAWL, KNEEL)
_____FINE HAND MOVEMENTS
_____REACHING
_____OTHER ACTIVITIES:_____

HAVE YOU HAD PHYSICAL THERAPY FOR THIS INJURY? YES/NO
IF YES, WHAT FACILITY AND WHAT TYPE? _____

ATTORNEY? YES/NO NAME/PHONE #_____
HOW LIKELY IS IT THAT YOU WILL RETURN TO YOUR FORMER JOB? (CIRCLE ONE)
Very likely Somewhat likely Neither likely nor unlikely Somewhat unlikely Very Unlikely