Functional Capacity Evaluation Intake Form

Howard Physical Therapy

Name: (Dr. /Mr. /Mrs. /Ms.) _____ Date: ____/____/____

Address: _____ Home Phone: _____

City: _____ State: _____ Zip: _____ Work Phone: _____

Social Security Number: _____-____-_____ Date of Birth: ____/____/____

Person to be notified in case of emergency: _____ _____
(name) (phone number)

Referring Physician: _____

Have you had a previous Functional Capacity Evaluation? ___ YES ___ No

If Yes, WHEN, WHERE and for WHAT body part? _____

Are you currently receiving any home health services? (i.e. nursing, therapy, lab tests) ___Yes ___ No

Party Responsible for Payment: ___ Self ___ Workers' Compensation ___ No-Fault
___ Attorney (please provide name) _____

If Work-Related, please provide the following information:

Employer: _____ Occupation: _____

Address: _____ Currently Working: __ Yes __ No

If you have returned to work, are you at ___ regular job ___modified job ___new position ___new employer

Insurance Carrier: _____

WCB#: _____ Carrier Case #:_____ Date of Injury: _____

I understand that if I do not provide the correct information required for billing, I may be personally responsible for all expenses associated with services rendered. Expenses may include interest charges, collection fees, legal/court costs. I hereby give permission to Howard Physical Therapy, PLLC to perform the Functional Capacity Evaluation requested and to release all necessary medical information to parties responsible for payment. I understand that I have the right to terminate any or all parts of the evaluation at any time and I am responsible for notifying the evaluator of any and all changes in my symptoms as they occur.

Signature: _____ Date: _____

What body part are you here for? (i.e. neck, back, knee, etc.) _____

What are your primary complaints? (please circle all that apply)

Pain Weakness Stiffness Numbness Spasm Decreased Motion
Swelling Poor Balance Walking Other _____

Please describe what you were doing at the time of your injury:

_____
_____

Have you had a similar injury before? ___ No ___ YES (if yes, please describe injury, date and any treatment received)

_____
_____

Please rate your pain intensity from 1-10 (10 is most severe): Current: ____ Worst: ____ Best: ____

Briefly describe your pain: (i.e. shooting, burning, etc.) _____

Where are your symptoms located? _____

What makes your symptoms better? _____

What makes your symptoms worse? _____

What medications are you currently taking: _____

Have you received any treatment, including surgery for this condition? ___ NO ___ YES (if yes, please list below)

_____
_____
_____

Have you undergone any diagnostic testing? ___ NO ___ YES (if yes, please check below and list location/s)

☐ X-Ray ☐ CT Scan ☐ MRI ☐ EMG/NCV ☐ Other _____
Location/s: _____

Past Medical & Surgical History: (Please list any relevant information below):

_____
_____
_____

Additional Comments:

_____
_____
_____