

Physical Therapy Intake Form

(Please fill out completely)

Name: _____ Date: _____

DOB: _____ Age: _____ Height: _____ Weight: _____

Current Complaints (What brought you to Physical Therapy?)

1. _____ How long? _____
2. _____ How long? _____
3. _____ How long? _____

How many days ago did the condition begin?

- 0-7 days 8-14 15-21 22-90
 91 days to 6 mos. Over 6 mos. ago

Have you been treated for this problem? (PT, Chiropractic, Massage, Injections) _____

Have you received any special tests for this problem? (X-ray, MRI, blood tests, etc.) _____

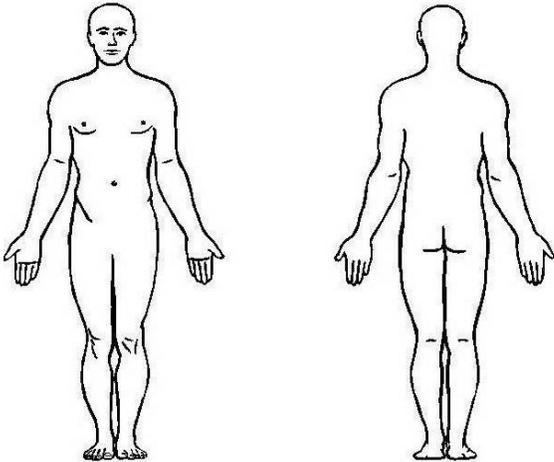
Have you had surgery for this problem? If so, when? _____

My symptoms are currently: getting better getting worse staying the same

I should not do physical activity that might make my pain worse: Completely Agree Somewhat Agree Unsure
 Somewhat Disagree Completely Disagree

Do you expect to return to the activity levels you were at prior to developing these symptoms? Yes No

Please mark the location of your pain



List 3 positions or activities that make your symptoms worse

1. _____
2. _____
3. _____

List 3 positions or activities that make your symptoms better

1. _____
2. _____
3. _____

Please describe your pain (numbness, stabbing, dull, burning, etc.)

How often have you completed at least 20 minutes of exercise, such as jogging, cycling or brisk walking, prior to the onset of your condition?

- at least 3 times per week once or twice per week
 seldom or never

Using the 0 to 10 scale, with 0 being "no pain" and 10 being "worst pain imaginable, please describe":

Your current level of pain while completing this survey: 0 1 2 3 4 5 6 7 8 9 10

The best your pain has been during the past 24 hours: 0 1 2 3 4 5 6 7 8 9 10

The worst your pain has been during the past 24 hours: 0 1 2 3 4 5 6 7 8 9 10

Medical Screening Information

Please fill out completely so we can better understand your overall health and possible contributing factors to your problem

Occupation, including activities that make up your work day (sitting, driving, how long, etc.) _____

Leisure activities including exercise routines _____

Are you on any work restrictions from your doctor? _____

Do you use tobacco (smoke/chew), alcohol or caffeine? _____

Have you ever had cancer? Yes No Body part/type _____ When? _____

Have you ever taken steroid medications for any medical condition? Yes No Name: _____

Have you (circle one) ever taken or are currently taking a blood thinner or anti-coagulant medication? Yes No

Do you have a pacemaker, transplanted organ, joint replacement, breast implants, or any other implants? Yes No

If yes, please explain: _____

Previous surgeries or injuries, including date:

_____	_____
_____	_____
_____	_____

Have you had a cold or other recent infection in the last 6 weeks? Yes No _____

Current medications (include pills, skin patches, injections, non-prescription/over-the-counter drugs, and supplements)

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

Are you allergic to any medications, tape, or latex? _____

Have you recently noted any of the following? Check all that apply.

- | | | |
|---|---|--|
| <input type="checkbox"/> fatigue | <input type="checkbox"/> numbness or tingling | <input type="checkbox"/> constipation |
| <input type="checkbox"/> fever/chills/sweats | <input type="checkbox"/> muscle weakness | <input type="checkbox"/> diarrhea |
| <input type="checkbox"/> nausea/vomiting | <input type="checkbox"/> dizziness/lightheadedness | <input type="checkbox"/> shortness of breath |
| <input type="checkbox"/> weight loss/gain | <input type="checkbox"/> heartburn/indigestion | <input type="checkbox"/> fainting |
| <input type="checkbox"/> difficulty maintaining balance | <input type="checkbox"/> difficulty swallowing | <input type="checkbox"/> coughing |
| <input type="checkbox"/> falls | <input type="checkbox"/> changes in bowel or bladder function | <input type="checkbox"/> headaches |

Have you ever been diagnosed with any of the following conditions? Check all that apply.

- | | | |
|---|--|--|
| <input type="checkbox"/> cancer | <input type="checkbox"/> depression | <input type="checkbox"/> thyroid problems |
| <input type="checkbox"/> heart problems/disease | <input type="checkbox"/> lung problems/respiratory disease | <input type="checkbox"/> diabetes |
| <input type="checkbox"/> chest pain/angina | <input type="checkbox"/> tuberculosis | <input type="checkbox"/> osteoporosis/osteopenia |
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> asthma | <input type="checkbox"/> multiple sclerosis/Parkinson's |
| <input type="checkbox"/> circulation problems | <input type="checkbox"/> rheumatoid arthritis | <input type="checkbox"/> epilepsy/seizures |
| <input type="checkbox"/> peripheral vascular disease | <input type="checkbox"/> osteoarthritis | <input type="checkbox"/> eye problem/infection |
| <input type="checkbox"/> blood clots | <input type="checkbox"/> other arthritic condition | <input type="checkbox"/> glaucoma/macular degeneration |
| <input type="checkbox"/> stroke or TIA | <input type="checkbox"/> bladder/urinary tract infection | <input type="checkbox"/> ulcers/gastrointestinal disease |
| <input type="checkbox"/> anemia | <input type="checkbox"/> kidney problem/infection | <input type="checkbox"/> liver problems |
| <input type="checkbox"/> bone or joint infection | <input type="checkbox"/> sexually transmitted disease/HIV | <input type="checkbox"/> hepatitis/HIV/AIDS |
| <input type="checkbox"/> chemical dependency, i.e. alcoholism | <input type="checkbox"/> pelvic inflammatory disease | <input type="checkbox"/> pneumonia |

Medical Screening Information (continued)

We are interested in how you feel about how well you are able to do your usual activities. This information will help us take better care of you. Please answer the questions based on the problem for which you are receiving treatment. If you do not do or have not done this activity, please make your best guess as to which response is most accurate.

Neck

Today, does or would your health problem limit...	Extreme difficulty or unable to do	Quite a bit of difficulty	Moderate difficulty	A little bit of difficulty	No difficulty
1. Looking up to see a bird?					
2. Performing personal care activities like washing, dressing, bathing?					
3. Moving your head quickly, such as following a loud noise?					
4. Performing recreational activities that require little effort, i.e. card playing, knitting, etc.?					
5. Turning to look behind you to drive a car?					
6. Turning over in bed?					
7. Sitting and reading a book for 1 hour?					
8. Changing a light bulb overhead?					
9. Sitting, performing light desk work for 8 hours?					
10. Performing recreational activities in which you take some force or impact, i.e. golf, hammering, tennis, etc.?					

My symptoms: come and go are constant are constant but change with activity

How are you able to sleep at night due to your symptoms? No problem sleeping difficulty falling asleep
 sleep only with medication awakened by pain

When are your symptoms the worst? Morning Afternoon Evening Night After exercise

When are your symptoms the best? Morning Afternoon Evening Night After exercise

What are your goals for physical therapy? _____

Signature: _____ Date: _____