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.) _____

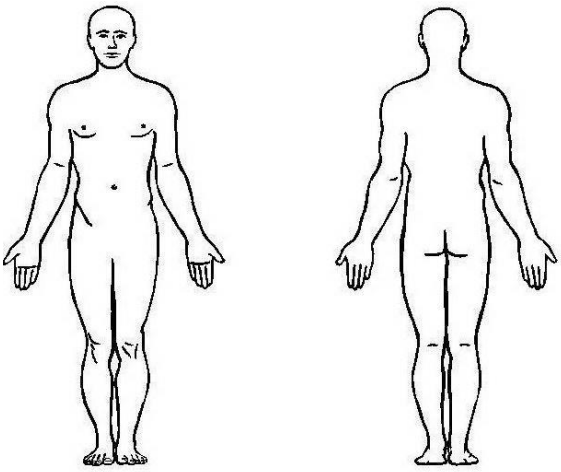
Have you had surgery for this problem? If so, when? _____

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.

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

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

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

Shoulder

Today, how much difficulty do you or would you have…	I can't do this	Much difficulty	Some difficulty	Little difficulty	No difficulty
1. Combing or brushing hair using your affected arm?					
2. Using your affected arm to place a can of soup (1 lb) on a shelf at shoulder height?					
3. Using your affected arm to pick up and drink out of a full glass of water?					
4. Using your affected arm to reach a shelf that is at shoulder height?					
5. Using your affected arm to reach an overhead shelf?					
6. Pushing yourself out of a chair using both arms?					
7. Reaching across the middle of the table with your affected arm to get a salt shaker while sitting?					
8. Getting a scarf or necktie over your head and around your neck, using both hands?					
9. Putting your deodorant under the arm opposite your affected shoulder?					
10. Pulling a chair out from a table using your affected arm?					

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: _____