PHYSICAL THERAPY INTAKE FORM

Personal Information

Name:_____ Address:_____

City/Zip:_____ Phone:_____ Email:_____

Date of Birth:_____ Sex:_____

Who Referred You:

History

Exercise Frequency:_____

Exercise Type(s):_____

Are you pregnant? _____

Do you have a pacemaker?_____

Previous complaints/surgeries:_____

Previous diagnoses:_____

Current medications:

Complaint

What is your major complaint?_____

Start Date:_____ Symptoms:_____

Doctors seen for complaint:_____

Previous treatment for complaint:_____

Symptom-Aggravating Factors:_____

Symptom-Relieving Factors:_____

Time of Day Symptoms are Best: _____ Time of Day Symptoms are Worst:_____

Current Duration of Pain: ☐ Intermittent ☐ Constant ☐ With Certain Motions

Current Level of Pain: ☐ Mild ☐ Moderate ☐ Severe ☐ Excruciating Pain Scale 1-10:_____

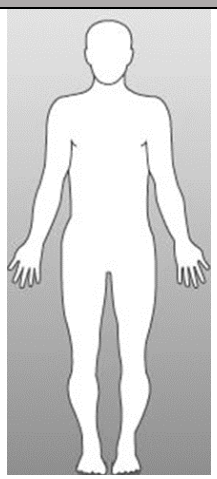
Do You Have Any of the Following? (Check all that apply)

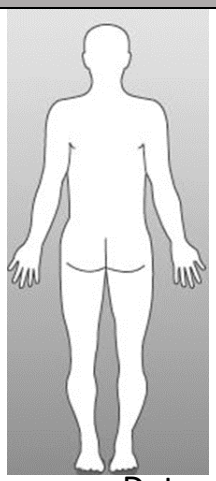
☐ AIDS/HIV	☐ Anemia	☐ Angina	☐ Arteriosclerosis
☐ Osteoarthritis	☐ Asthma	☐ Blood Clots	☐ Bone Infection
☐ Cancer	☐ Chemical Dependency	☐ Circulation Problems	☐ Depression
☐ Diabetes	☐ Seizure Disorder	☐ Eye Infection	☐ Heart Problems
☐ Hemophilia	☐ High/Low Blood Pressure	☐ Liver Problems	☐ Lung Problems
☐ Multiple Sclerosis	☐ Musculoskeletal Problems	☐ Numbness/Tingling	☐ Pneumonia
☐ Stroke	☐ Tuberculosis	☐ Urinary Incontinence	☐ Rheumatoid Arthritis

Allergies (Please Describe) : _____ _____ _____

_____ _____ _____ _____

Mark Areas of Discomfort





Signature:_____ Date:_____