

Patient Intake Form

To help us perform the most thorough physical therapy evaluation possible, please be as accurate as possible when answering the questions below.

Date: _____

Name: _____ Age: _____

Reason for today's visit: _____

When did symptoms start: _____

How were you injured: _____

When was your last physical? _____

List any known allergies: _____

Are you: Working Medical leave Retired Medically disabled

What type of work are/were you doing: _____

Do you participate in regular exercise? Yes No

Please describe: _____

Past Medical History

Have you or your immediate family ever been diagnosed with:

	Self	Family
Cancer.....	Y N	Y N
Diabetes.....	Y N	Y N
High Blood Pressure.....	Y N	Y N
High Cholesterol.....	Y N	Y N
Heart Disease.....	Y N	Y N
Angina/chest pain.....	Y N	Y N
Stroke.....	Y N	Y N
Lung problems.....	Y N	Y N
Neurological disease.....	Y N	Y N
Osteoporosis.....	Y N	Y N
Osteoarthritis.....	Y N	Y N
Rheumatoid Arthritis.....	Y N	Y N
Seizures.....	Y N	Y N
Thyroid problems.....	Y N	Y N

OTHER: _____

Do you currently or have you in the past smoked tobacco? Yes No

If yes, _____ Pack(s)/day _____ Years

Last tobacco use _____

Have you been exposed to second hand smoke for and extended period of time? Yes No

Do you drink alcoholic beverages: Yes No

If yes, how many drinks do you have on average per week? _____/wk.

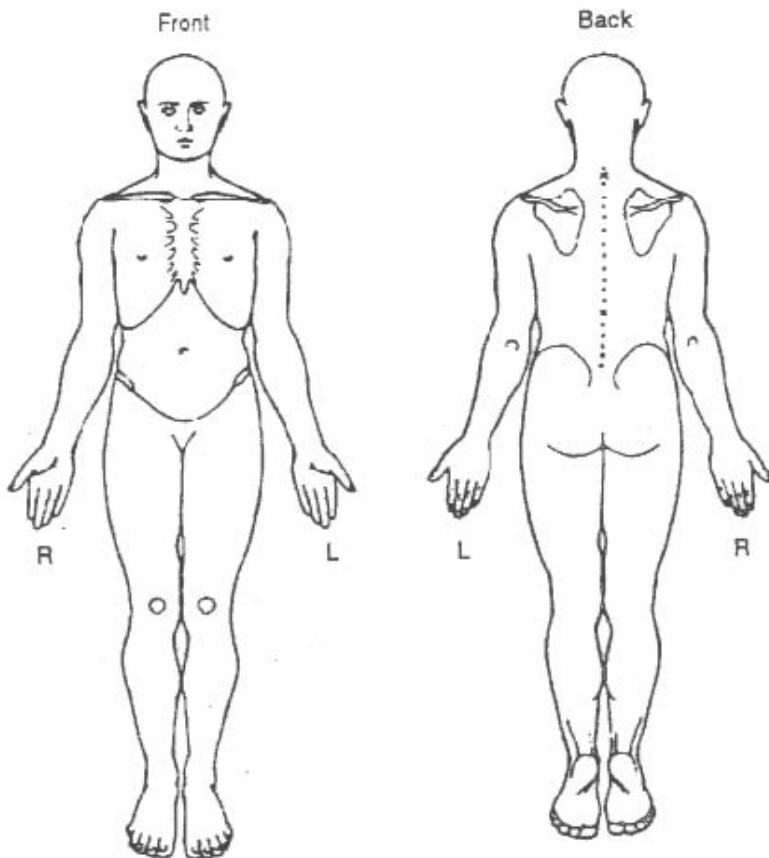
Do you drink caffeinated beverages: Yes No

If yes, how much do you drink on average per day? _____ ounces

In the past 3 months have had or have:

Nausea/Vomiting.....Y	N	Fever/Chills/Sweats.....Y	N
Unexplained weight loss or gain...Y	N	Numbness or tingling.....Y	N
If yes, where: _____			
Change in appetite.....Y	N	Difficulty swallowing.....Y	N
Change in bowel or bladder Function.....Y	N	Shortness of breath.....Y	N
Dizziness.....Y	N	Upper respiratory infection.....Y	N
Urinary tract infection.....Y	N		

Using the diagram below, please indicate where you are currently experiencing symptoms.



Describe the quality of your pain:
(circle all that apply)

- Burning
- Achy
- Sharp
- Dull
- Other:

Rate your pain on scale of 0-10 (0=no pain, 10=worst pain):

at rest _____ ; at worst _____

Are your symptoms: (circle one) Improving Staying the same Getting worse
Do your symptoms wake you up at night: (circle one) Yes No

Please list all current medications you are taking, dosages, and reason for taking:

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____
- 6. _____
- 7. _____
- 8. _____
- 9. _____
- 10. _____

List ALL previous surgeries and approximate dates:

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____

List any other health concerns today that may not be related to the problem that brought you here?
