

Patient Intake Form

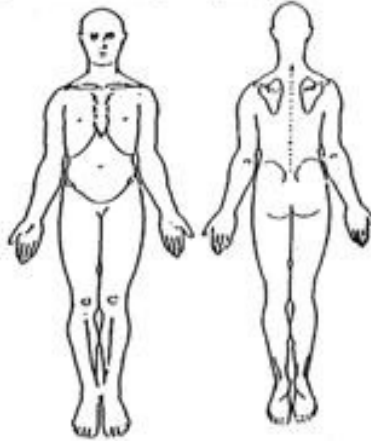
Name _____ Date _____

Please describe the problem for which you are coming to Physical Therapy.

When did your pain or problem start? _____ / _____ / _____
Month Day Year

What, in your opinion, caused this problem?

Please mark on the diagram where your pain/problem is **now, at this stage of your recovery.**



Have you ever had this problem before? Yes No

If so, when? _____ / _____
Month Year

What was helpful? _____

Have you had physical therapy before? Yes No

If so, for what kind of injury? _____

What makes your pain/problem worse? *Please be as specific as possible.*

What makes your pain/problem better? *Please be as specific as possible.*

Are you currently seeing anyone else for help with this problem? Yes No

If so, who? _____

List ALL the medications, including over-the-counter ones, that you are taking now.
(You do not have to list the doses.)

Please Continue On Back

What is your occupation? _____

If employed, have you been taken off the job or placed on restricted duty by your physician? Yes No

Have you had x-rays, MRI, CT scan or other diagnostic tests? Yes No

If so, which? _____

What were the results? _____

Do you have any of the following health problems or conditions? Please check all that apply and write in any not found on the list.

- | | |
|---|---|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Neurologic Disorders |
| <input type="checkbox"/> Balance Problems | <input type="checkbox"/> Pace Maker or Neuro Implant |
| <input type="checkbox"/> Bowel or Bladder Control Problems | <input type="checkbox"/> Poor Endurance |
| <input type="checkbox"/> Cancer or History of Cancer | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Sleeping Disturbance |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Smoking, _____ packs per day |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Stroke or TIA |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Sudden Weight Gain |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Sudden Weight Loss |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Recent Surgery _____ |
| <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Weakness |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Other |
| <input type="checkbox"/> History of Orthopedic Injury/Surgery | |
| <input type="checkbox"/> Back | <input type="checkbox"/> Neck |
| <input type="checkbox"/> Head Injury | <input type="checkbox"/> Shoulder |
| <input type="checkbox"/> Hips | <input type="checkbox"/> Upper Extremity |
| <input type="checkbox"/> Lower Extremity | <input type="checkbox"/> Other _____ |

What is your primary goal for coming to physical therapy?

Neck and Back Patients, Please Continue...

> Please answer the following ONLY if you are here for neck, upper back or lower back pain. <

Do you have any problems with loss of bowel or bladder control? Yes No

Have you recently rapidly gained or lost weight? Yes No

If so, how much weight in how much time? _____

Do you have any numbness or tingling in the genital area? Yes No

Do you have any lip or mouth tingling? Yes No

Do you experience any arm or leg weakness or numbness? Yes No