



Intake Form

Name: _____ Age: _____ DOB: _____ Sex: Male Female

E-mail: _____ Phone: _____

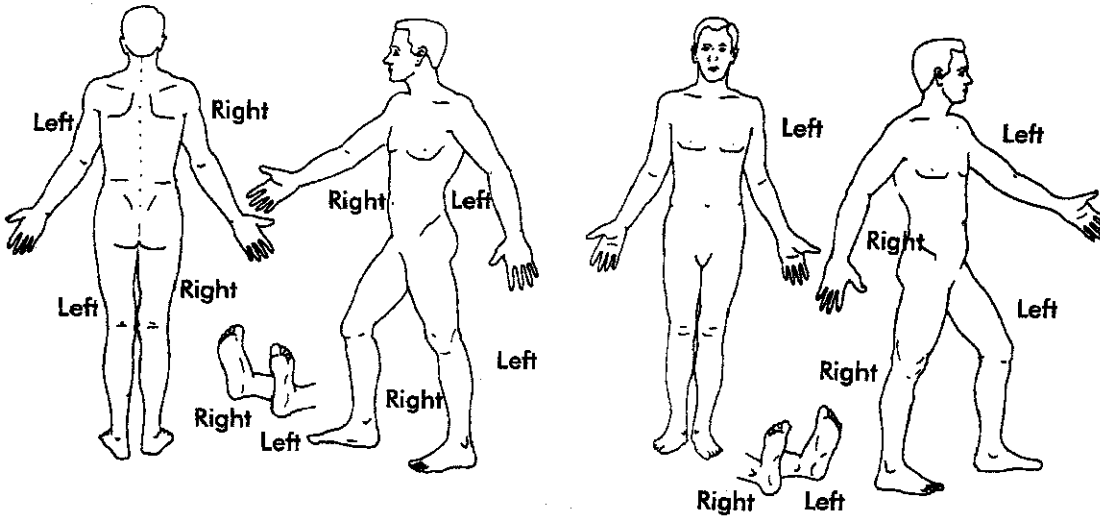
Diagnosis/Injury: _____

Date of injury or onset of complaint(s)? _____

Chief Complaint: _____

Have you received physical therapy treatment this calendar year? Yes No

Do you have any pain? Yes No if yes, please mark the areas on the drawing below.

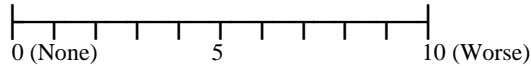


How do you describe your pain? (Circle all that apply)

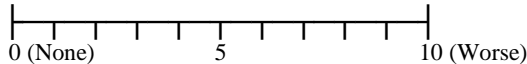
-Throbbing -Sharp -Stabbing -Burning -Shooting -Nagging -Cramping -Numbness -Dull ache

On the following scale of 0-10, how would you rate your pain?

At Rest:



With Activity:



Is pain constant or intermittent? _____

What makes your pain increase? _____

What, if anything, eases your pain? _____

Do you have any metal or any other implants in your body? Yes No If yes, where?

Do you smoke? Yes No Are you pregnant? Yes No N/A

Medical History (check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> High BP |
| <input type="checkbox"/> Allergies: _____ | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> HIV |
| <input type="checkbox"/> Broken Bones/Fractures | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Multiple sclerosis |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Parkinson's disease |
| <input type="checkbox"/> Head injury | other: _____ |

Are you having any of these symptoms? (Check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Pain at Night |
| <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Visual Problems |
| <input type="checkbox"/> Difficulty Sleeping | <input type="checkbox"/> Weakness |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Coordination Problems |

Current Medications: _____

Surgical History (Recent Dates): _____

What was your exercise program prior to your injury? _____

What are your goals for physical therapy? _____

How did you hear about our practice? _____

I will advise the therapist if there are any changes in my physical condition that would alter my response to any of the questions on this form.

Patient Signature: _____

Date: _____

Signature of Parent/Guardian: _____

Date: _____