Align+Shine
PHYSICAL THERAPY

Intake Form

Patient Information

Name_____

Male_____**Female**_____ **Date of Birth**____/_____/_____**Age**_____

Street Address_____ **City**_____**State**___ **Zip**_____

Preferred contact phone number_____ **Secondary number**_____

Email:_____

Occupation/Employer Name:_____

Hobbies:_____

Emergency contact Name:_____**Phone number:**_____

Who Referred you to Physical Therapy?_____

Physician Information

Primary Care Physician Name:_____

PCP Address:_____

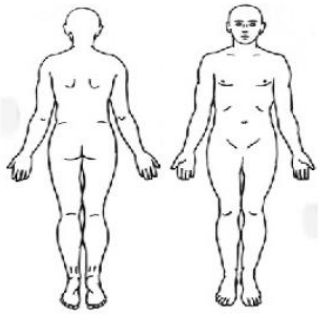
PCP Phone #:_____

Name of Specialist or other Physicians involved in current care:_____

_____

Health Information:

Please note areas of pain on the body chart below:



Today's Date: _____ **Date of Injury/onset:** _____

Briefly Describe your symptoms:_____

Describe how your condition or injury occurred:_____

Have you ever had these symptoms before (circle): Yes / No If so, when: _____

What eases your symptoms?_____**What aggravates your symptoms?**_____

Do symptoms wake you at night? Yes □ No □ How many times?_____

What activities at home, work, or recreational are you unable/struggling to perform?_____

_____

What goals do you hope to accomplish in Physical Therapy?_____

_____

Please check any tests that you have completed in treatment of this condition

□X-Ray □MRI □Bone Scan □Nerve Tests □Blood Tests □Other_____

Facility where tests were completed or ordering physician:_____

_____

The following is a list of common health problems. In the first column please indicate if you currently have, or have ever had any of the problems in the past. In the second column please comment on any current/past treatment, or impact on daily living.

	YES	NO	
Heart Disease	□	□	_____
Do you have a pacemaker	□	□	_____
Heart Attack	□	□	_____
High Blood Pressure	□	□	_____
Low Blood Pressure	□	□	_____
Lung Disease/Asthma	□	□	_____
Diabetes	□	□	_____
Ulcer or Stomach Disease	□	□	_____
Nausea/Vomiting	□	□	_____
Hernia	□	□	_____
Kidney Problem	□	□	_____
Liver/Gall Bladder problems	□	□	_____
Drug use	□	□	_____
Anemia or blood condition	□	□	_____
Ringing in the ears	□	□	_____
Cancer	□	□	_____
Sexual dysfunction	□	□	_____
Seizures/Fainting	□	□	_____
Dizziness/Vertigo	□	□	_____
Nerve disease/disorder	□	□	_____
Muscle disease/disorder	□	□	_____
Immune disease/disorder	□	□	_____
Hearing loss	□	□	_____
Vision loss	□	□	_____
Arthritis	□	□	_____
Allergies	□	□	_____
Skin Disorder	□	□	_____
Are you pregnant?	□	□	_____
Smoking/Tobacco use	□	□	_____
Bowel/Bladder irregularities	□	□	_____
Menstrual irregularities	□	□	_____
Stroke	□	□	_____
Osteoporosis	□	□	_____

Are you currently taking steroids or have a history of long-term steroid use? □Yes □ No
In the past year have you had any falls? □Yes □No If so, how many and were you injured?_____
Alcohol Status: □Non-Drinker □1-2 drinks per day □3 or more drinks per day
Do you drink caffeinated Beverages? □No □1-2 per day □3 or more drinks per day
How many hours do you sleep at night?_____

ARE YOU CURRENTLY HAVING OR HAVE EXPERIENCED ANY OF THESE SYMPTOMS IN THE PAST 3 MONTHS?
□Fever □Chills □Night Sweats □Shortness of Breath □Pins/Needles □Numbness □Skin Rash □Headaches
□Feeling Blue/Discouraged □High Anxiety/Stress □Feeling life has no purpose □Feeling Fearful
□Unexplained Weight loss/Gain □Marital or relationship problems □Recent Loss of a loved one
Do you feel that your emotional issues impact your symptoms? □Yes □No

How many days per week do you exercise at least 30 minutes? _____ Type of Exercise_____

Surgeries with corresponding dates: _____
_____

Current Medications and reasons for taking (please include over the counter medications and supplements):
_____
_____

Signature: _____ Date: _____

Relationship to patient: _____

Thank you!