



Intake Form

Patient Information

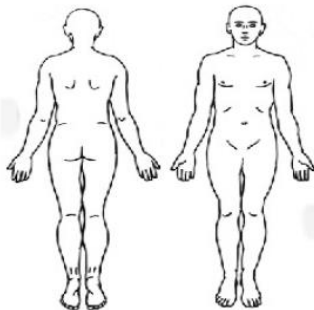
Name _____
Gender @ Birth (Circle) M or F. Pref. Pronouns _____ Date of Birth ____/____/____ Age ____
Street Address _____ City _____ State ____ Zip _____
Preferred contact phone number _____ Secondary number _____
Email: _____
Occupation/Employer Name: _____
Hobbies: _____
Emergency contact Name: _____ 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	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you have a pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lung Disease/Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ulcer or Stomach Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Nausea/Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hernia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Problem	<input type="checkbox"/>	<input type="checkbox"/>	_____
Liver/Gall Bladder problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Drug use	<input type="checkbox"/>	<input type="checkbox"/>	_____
Anemia or blood condition	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ringing in the ears	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sexual dysfunction	<input type="checkbox"/>	<input type="checkbox"/>	_____
Seizures/Fainting	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dizziness/Vertigo	<input type="checkbox"/>	<input type="checkbox"/>	_____
Nerve disease/disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Muscle disease/disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Immune disease/disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hearing loss	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vision loss	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Smoking/Tobacco use	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bowel/Bladder irregularities	<input type="checkbox"/>	<input type="checkbox"/>	_____
Menstrual irregularities	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	_____

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!