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PT Intake

To help us assess the cause of your problem, please complete this form before being seen by a physical therapist.

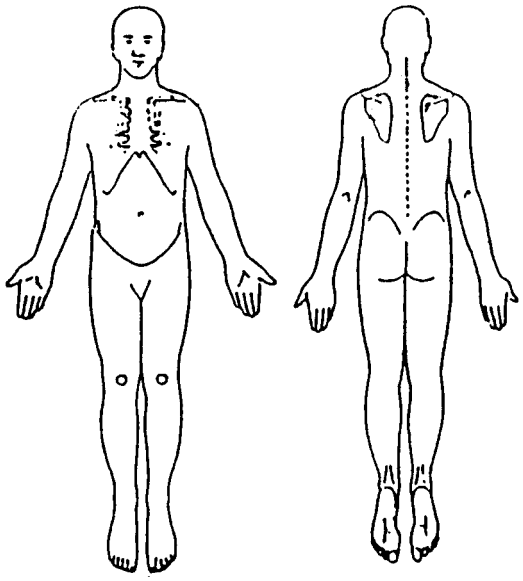
Name: _____

Date: _____

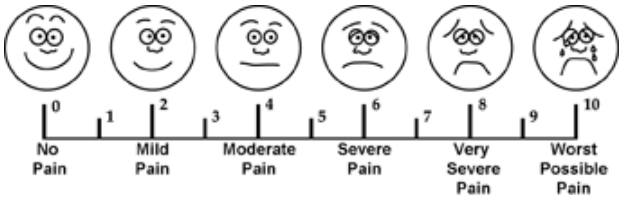
1. What is your *main* problem or complaint? _____
   A. Is this related to an injury or accident? Yes ☐ No ☐ Date of accident: _____
   If yes, check which applies: Work ☐ Motor Vehicle ☐ Other (specify) ☐ _____
   Any other areas of concern beside main issue?_____
2. Are you currently off work because of this problem? Yes ☐ No ☐ If yes, last day worked _____
3. How & when did your symptoms start?_____ Date: _____
4. Have you had this problem before? _____
5. What tests or treatment have you had for this problem? _____
6. What do your symptoms prevent you from doing? _____
7. Currently, would you say your health is (circle): excellent very good good fair poor
8. Circle if you have any of the following:

Weakness	Dizziness or nausea	Headaches or blurred vision
Numbness or tingling	Change in bowel or bladder	Pain with deep breath/coughing/sneezing
Balance problems or Falls		

9. Please indicate painful areas on pictures to your right →→→→→→



10. **Circle** a number to rate the intensity of your pain.



11. Which number describes your most severe pain in last 48 hours?
    _____
12. Which of these words describe your pain? Circle all that apply.

Sharp	Burning	Intermittent
Dull	Numb/tingling	Radiating
Aching	Constant	Other _____

13. What positions or activities **increase** your pain?

_____

_____

Decrease your pain?_____

PLEASE COMPLETE REVERSE SIDE.

Name: _____

Date: _____

14. What are your goals for physical therapy?

_____

GENERAL MEDICAL INFORMATION:

15. Height: _____ ft _____ in Weight: _____ lbs.

16. Tobacco Use:

☐ Yes, currently ☐ No, Quit less than 1 year ago ☐ No, Quit greater than 1 year ago ☐ No, Never used

17. How many drinks containing alcohol do you have, on average, per week? _____

18. Please list **all** medications you are taking, including dosage and reason for taking: _____

_____

_____

19. Have you had any falls in the past year? Yes No If Yes, how many and were you injured? _____

_____

20. Describe your regular recreational/exercise/sports activity in the last 6 months; indicate any activities which you've stopped or modified due to your current symptoms. (For ex., walk 30 mins, 3x/week, tennis 1 hr., 1x/week.)

_____

On average, how many minutes per week do you participate in moderate exercise, such as a brisk walk, cycling, etc.?

☐ None ☐ Less than 90 minutes/week ☐ 90-149 minutes/week ☐ 150 or more minutes/week

21. Please list all past surgeries, with approximate dates: _____

_____

22. Have you or anyone in your immediate family EVER been diagnosed as having any of the following conditions?

(S=Self, F=Family Member)

	S	F		S	F		S	F
Allergies			Diabetes			Obesity		
Alzheimer's/Dementia			Dizzy Spells			Osteoporosis		
Anemia			Emphysema/COPD/Bronchitis			Parkinson's		
Anxiety			Epilepsy/Seizures			Pediatric Congenital Cond.		
Arthritis			Fractures (specify below)		na	Peripheral Neuropathy		
Asthma			Gallbladder Problems			Pregnant, Currently		na
Bipolar Disorder			Gastrointestinal Problems			Rheumatoid Arthritis		
Brain Injury			Hepatitis			Skin Problems		
Cancer			High Blood Pressure			Sleep Dysfunction		
Cardiac Conditions			HIV/AIDS			Speech Problems		
Cardiac Pacemaker			Incontinence			Spinal Cord Injury		
Chemical Dependency			Jaw Pain/TMJ			Strokes		
Circulation Problems			Kidney Problems			Thyroid Disease		
Degen. Joint Disease			Metal Implants		na	Tuberculosis		
Depression			Multiple Sclerosis			Vision Problems		

Anything else you want us to know _____