Physical Therapy Intake Form

Personal Information

Name: _____ Date: _____

Address: _____

Phone: _____ Email: _____

DOB: _____ SSN: _____

Who referred you? _____

History

Exercise Frequency: _____ Exercise Type(s): _____

Do you smoke? _____ Have you ever smoked? _____ How Often? _____

Are you pregnant? _____ Do you have a Pacemaker? _____

Allergies: _____

What medications are you currently using? _____

Previous complaints/surgeries: _____

Previous diagnoses/medications: _____

Complaint

What is your major complaint? _____

Start Date: _____ Possible Cause: _____

Symptoms: _____

Previous doctors seen for complaint: _____

Previous treatment for complaint: _____

Symptom-Aggravating Factors: _____

Symptom-Relieving Factors: _____

Time of Day Symptoms are Best: _____ Time They Are Worst: _____

Current Duration of Pain: ☐ Intermittent ☐ Constant ☐ With Certain Motions

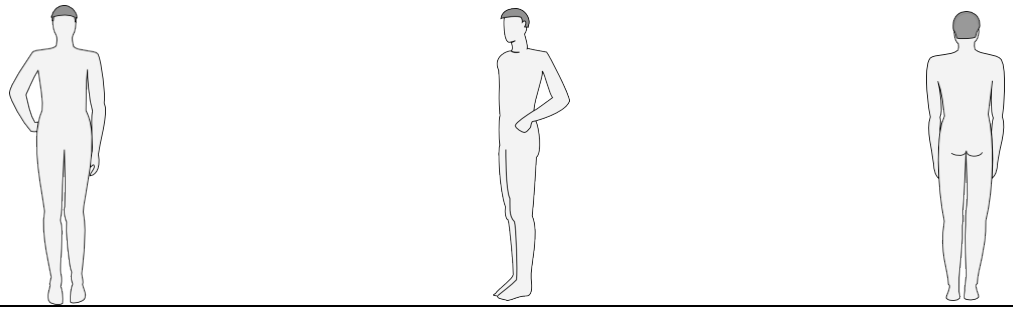
Current Level of Pain: ☐ Mild ☐ Moderate ☐ Severe ☐ Excruciating

Is your pain getting better or worse? _____ Have you had this injury before? _____

Do You Have Any of the Following Today? (Check All That Apply)

☐ AIDS/HIV	☐ Anemia	☐ Angina	☐ Arteriosclerosis
☐ Arthritis	☐ Asthma	☐ Blood Clots	☐ Bone Infection
☐ Cancer	☐ Chemical Dependency	☐ Circulation Problems	☐ Depression
☐ Diabetes	☐ Epilepsy	☐ Eye Infection	☐ Heart Problems
☐ Hemophilia	☐ High/Low Blood Pressure	☐ Joint/Bone Infection	☐ Liver Problems
☐ Lung Issues	☐ Multiple Sclerosis	☐ Musculoskeletal Problems	☐ Pneumonia
☐ Stroke	☐ STD	☐ Tuberculosis	☐ Urinary Infection

Mark Areas of Discomfort



_____ _____

Signature Date