Patient Intake Form

Date:__________________

Name:____ Date of Birth:_____________________

Referring Doctor:___________________________ Primary Doctor:_________________________

What is your primary reason for physical therapy?_____________________________________

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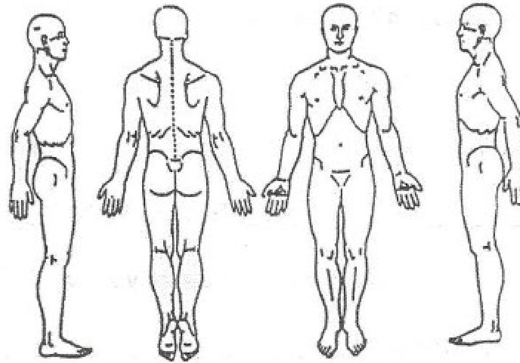
Please mark areas of concern on the diagram below:



Medical History (please check all that apply)

__ Heart Disease	__ Alzheimer's	__ Osteoarthritis	__ Heart Attack
__ Spinal Cord Injury	__ Rheumatoid Arthritis	__ Pacemaker	__ Brain Injury
__ Pregnancy	__ Stroke	__ Systemic Infection	__ Tobacco use
__ High Blood Pressure	__ Autoimmune disease	__ Substance abuse	__ Diabetes
__ Chronic Pain Disorder	__ History of Cancer	__ Fracture	__ Neurologic Disorder
__ Muscular Dystrophy	__ Parkinson's	__ Osteoporosis	__ Allergies
__ Fibromyalgia	__ Cauda Equina Syndrome	__ Cerebral Vascular Accident (Stroke)	

__ Other (please specify)

If yes to any of the above, please specify: ____

____

Surgical History, please specify:____

____

Previous Therapy: ____

Please List your Medications:

____________________ ____________________ ____________________

____________________ ____________________ ____________________

____________________ ____________________ ____________________

____________________ ____________________ ____________________

Have you recently or are you currently experiencing any of the following symptoms?

__ Trouble with sleeping

__ Bowel or bladder changes

__ Dizziness or vertigo

__ Current infection

__ Nausea/vomiting

__ Shortness of breath or decrease in stamina?

__ Do you use any assistive devices?

__ Bruising or bleeding disorders

__ Skin changes, rashes, or discoloration

__ Visual changes

__ Sensation changes (numbness, tingling, etc.)

__ Recent change in your weight or appetite

__ Temperature sensitivity

Are there any other concerns we need to be aware of during your care?__________________

____

How would you rate your general health? (circle one)

Poor Fair Good Very Good Exceptional

Overall activity level: (circle one) Sedentary Light Moderate Heavy

Primary Exercise or Sport: ________________ **Time per Week:** ______________________

Are you currently working? ____**If so, what is the nature of your work?** __________________

What are your goals for physical therapy? ____

____

Who can we thank for this referral? ____

Thank you for your patience and valuable time!