Physical Therapy Intake Form

Personal Information

Name: ______________________ Date: ______________
Address: ______________________
Phone: ______________ Email: ______________
DOB: ______________ Sex: ______________
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: ______________________

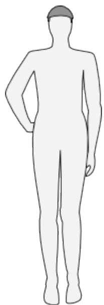
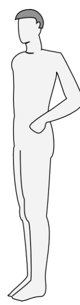
Complaint

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