

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-Agravating 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)

- | | | | |
|--------------------------------------|--|---|--|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Anemia | <input type="checkbox"/> Angina | <input type="checkbox"/> Arteriosclerosis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Asthma | <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Bone Infection |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Circulation Problems | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Eye Infection | <input type="checkbox"/> Heart Problems |
| <input type="checkbox"/> Hemophilia | <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Joint/Bone Infection | <input type="checkbox"/> Liver Problems |
| <input type="checkbox"/> Lung Issues | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Musculoskeletal Problems | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> STD | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Urinary Infection |

Mark Areas of Discomfort



Signature _____

Date _____