Physical Therapy New Patient Intake Form

Patient Name: _____ Today's Date:_____ Date of Birth: _____
Male Female (circle one) Age: _____ Height: _____ Weight: _____ Occupation: _____
Hrs/week: _____ Employer: _____ Business Phone: _____
Home Phone: _____ Cell Phone: _____ Email: _____
Mailing Address: _____ City: _____ State: _____ Zip: _____
Primary Care Physician: _____ Phone: _____ Next visit: _____
Specialist Physician: _____ Phone: _____ Next Visit: _____

Are you currently receiving ANY home health services: □Yes □No

Do you have an adhesive allergy: □**Yes** □**No** Work Related: □**Yes** □**No**
Do you have a latex allergy: □**Yes** □**No** Is your injury Auto Related: □**Yes** □**No**
Are you currently taking anticoagulants (i.e. Coumadin, aspirin, Warfarin): □**Yes** □**No**
What kind? _____
Have you received any recent medical tests: □**Yes** □**No**
When? _____ Xrays MRI CT Scan other:_____
Do you regularly exercise? □**Yes** □**No**
If yes, how many hours a week & what activities: _____

Please complete this brief health questionnaire in regards to your current condition:

Chief Complaint: _____

Date of Onset: _____

Describe what caused the pain: _____

Was the Onset: (circle one) Gradual or Sudden Since onset, has it gotten: (circle one) Worse Better Same

Secondary or related complaint (if any): _____

SEVERITY OF PAIN:

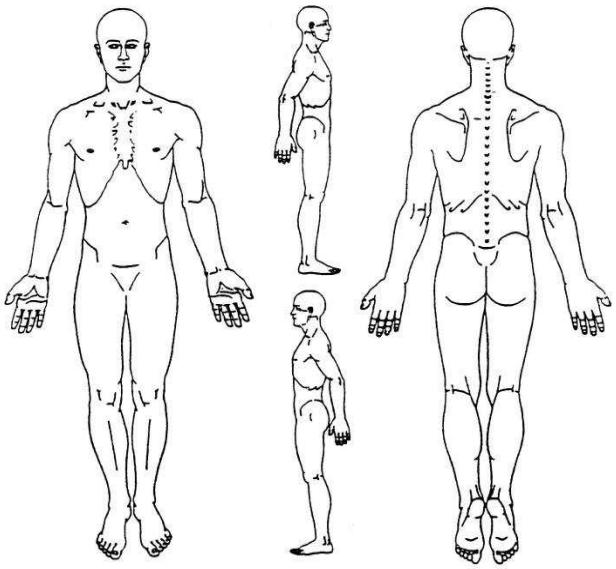
Circle the number which represents the intensity of your pain.

Current Pain Level 0 1 2 3 4 5 6 7 8 9 10

Best Pain Level 0 1 2 3 4 5 6 7 8 9 10

Worst Pain Level 0 1 2 3 4 5 6 7 8 9 10

PLEASE MARK WHERE YOUR PAIN IS LOCATED:



Describe the quality of the complaint/pain:

Sharp Dull/Ache Throbbing Tingling/Numbness
Radiating Pin point Burning Stabbing Other:_____

How often are you aware of the pain:

Intermittent (less than 25% of the time when awake) Occasional (25- 50% of the time when awake)
Frequent (50-75% of the time when awake) Constant (75-100% of the time when awake)

Does any of the following make the pain worse:

Lifting Bending Pushing Pulling Coughing Sneezing Bowel Movements Driving Riding
Sitting Walking Running Standing other:_____

Does your pain interrupt your sleep:

No difficulty Mild (5-7 Hours of Sleep) Moderate (4-5 Hours of Sleep)
Severe (2-4 Hours of Sleep) Complete (less than 2 Hours of Sleep)

Does it interfere with your daily activities:

Minimal (annoyance, no impairment) Slight (tolerated, some impairment)
Moderate (Marked Impairment) Marked (precludes any activity)

Does any of the following make it better:

Rest Laying down Sitting Walking Exercise other:_____

Have you tried any self-treatment or taken any medications (over the counter or Rx): □Yes □No

If yes, explain: _____ Results: _____

Have you detected any possible relationship of current complaint with any of the following:

Muscle Weakness Bowel/Bladder Problems Digestion Cardiac/Respiratory other: _____

Please check all that apply:

Does your home have:	Do you use:	Do you have difficulty with:
□Stairs, No Railing	□Cane	□Locomotion/Movement
□Stairs, With Railing	□Walker or Rollator	□Bed Mobility
□Ramps	□Manual Wheelchair	□Transfers
□Elevator	□Motorized Wheelchair	□Gait/Walking
□Uneven Terrain	□Hearing Aids	□Self Care
□Assistive Devices	□Glasses/Contacts	□Home Management

Check any conditions you have had:

Allergies	□Yes □No	Dizzy Spells	□Yes □No	MRSA	□Yes □No
Anemia	□Yes □No	Emphysema/Bronchitis	□Yes □No	Multiple Sclerosis	□Yes □No
Anxiety	□Yes □No	Fibromyalgia	□Yes □No	Muscular Disease	□Yes □No
Arthritis	□Yes □No	Fractures	□Yes □No	Osteoporosis	□Yes □No
Asthma	□Yes □No	Gallbladder Problems	□Yes □No	Parkinson's	□Yes □No
Autoimmune Disorder	□Yes □No	Headaches	□Yes □No	Rheumatoid Arthritis	□Yes □No
Cancer	□Yes □No	Hearing Impairment	□Yes □No	Seizures	□Yes □No
Cardiac Conditions	□Yes □No	Hepatitis	□Yes □No	Smoking/tobacco use	□Yes □No
Cardiac Pacemaker	□Yes □No	High Cholesterol	□Yes □No	Speech Problems	□Yes □No
Chemical Dependency	□Yes □No	High Blood Pressure	□Yes □No	Stroke	□Yes □No
Circulation Problems	□Yes □No	HIV/AIDS	□Yes □No	Thyroid Problems	□Yes □No
Currently Pregnant	□Yes □No	Incontinence	□Yes □No	Tuberculosis	□Yes □No
Depression	□Yes □No	Kidney Problems	□Yes □No	Vision Problems	□Yes □No
Diabetes	□Yes □No	Metal Implants	□Yes □No		

Falls History

Have you had and injury as a result of a fall in the past year? □Yes □No When:_____

Have you had two or more falls in the past year? □Yes □No Dates of Falls:_____

Medical History

Have you ever had any major illnesses, injuries, broken bones, hospitalizations, or surgeries? If yes, please list below:

Date	Injury/Fracture/Illness/Surgeries	Treatment	Results

Please list ANY medications you have used in the past week, or you may provide us with a current list.

Prescriptions	Dosage	Frequency	Route	Reason Taking

Please describe any other conditions or precautions, including any allergies not previously mentioned:

_____

_____

_____

The information I have given is to the best of my knowledge

_____

Patient or Guardian's Signature **Date**