

Physical Therapy New Patient Intake Form

Patient Name: _____ Today's Date: _____ Date of Birth: _____

Are you currently receiving ANY home health services? Yes No

Home Phone: _____ Cell Phone: _____ Email: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Height: _____ Weight: _____

Do you have an adhesive allergy: Yes No Is your injury 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? _____

Do you regularly exercise? Yes No

If yes, how many hours a week & what activities: _____

What percentage of your work is:

Sitting _____ Standing _____ Manual Labor: _____

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): _____

PLEASE MARK WHERE YOUR PAIN IS LOCATED:

SEVERITY OF PAIN:

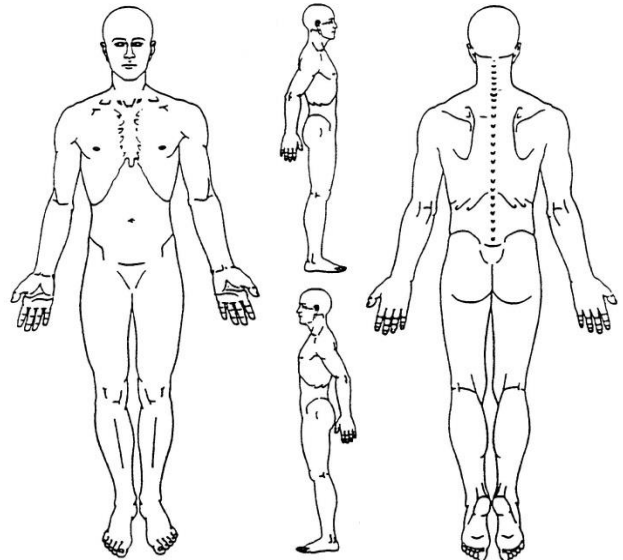
Circle the number which represents the intensity of your pain.



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



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)

What is your goal for therapy? _____

Check any conditions you have had:

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

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 |
|------|-----------------------------------|-----------|---------|
| | | | |
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| | | | |

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 |
|---------------|--------|-----------|-------|---------------|
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| | | | | |

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

Falls History

Have you had an 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: _____

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

Patient or Guardian's Signature

Date