Physical Therapy Existing 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:

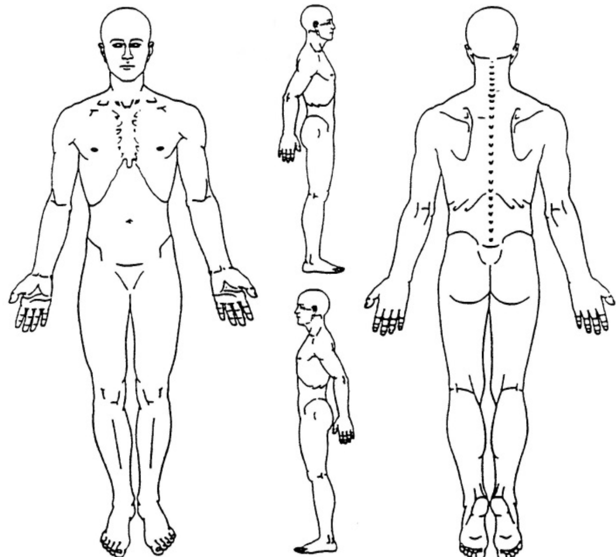
Circle the number which represents the intensity of your pain.

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

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:_____________________

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

____

Patient or Guardian's Signature **Date**