



Physical Therapy Intake

Name: _____ DOB: _____ Date: _____
Last First Middle

Address: _____
Street City State Zip

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)

- | | | | |
|--------------------------------------|--|---|--|
| <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

