Physical Therapy Intake Form

Referring physician: _____ **Name:** _____

Phone: _____

Reason for referral:

Please check any of the following whose care you are under:

- [ ] Medical doctor
- [ ] Psychiatrist/Psychologist
- [ ] Osteopath
- [ ] Physical therapist
- [ ] Chiropractor
- [ ] Occupational therapist
- [ ] Other

If you have seen any of the above during the past three months, please describe for what reason (illness, medical condition, routine physical, etc.):

Date of injury or when symptoms began: _____ dd / mm / yyyy

Is this injury related to any of the following:

- [ ] Work
- [ ] Auto accident
- [ ] Other
- [ ] N/A

Briefly describe your injury/symptoms:

Did you have surgery for the above injury or symptoms?

◯ No ◯ Yes

Are you presently taking any medication? If yes, please list name, for what condition, and how long.

List any medications you are allergic to:

Have you ever taken steroid medications for any reason?

◯ No ◯ Yes

Do you have a pacemaker?

◯ No ◯ Yes

Are you currently pregnant or think you might be pregnant?

○ No ○ Yes

Have you ever been diagnosed as having any of the following conditions?

- ☐ Blood clots
- ☐ High blood pressure
- ☐ Circulation problems
- ☐ Asthma
- ☐ Drug or alcohol addiction
- ☐ Diabetes
- ☐ Multiple sclerosis
- ☐ AIDS
- ☐ MRSA
- ☐ Rheumatoid arthritis
- ☐ Thyroid problems
- ☐ Heart problems
- ☐ Other
- ☐ Tuberculosis
- ☐ Stroke
- ☐ Stomach ulcers
- ☐ Emphysema/Bronchitis
- ☐ Epilepsy
- ☐ Depression
- ☐ Ehlers-danlos syndrome
- ☐ Hepatitis
- ☐ Other arthritic conditions
- ☐ Osteoporosis
- ☐ Cancer
- ☐ Kidney disease

During the past month, have you been feeling down, depressed, or hopeless?

○ No ○ Yes

Please check if anyone in your immediate family (parents, brothers, sisters) have ever been treated for any of the following?

- ☐ Diabetes
- ☐ Heart disease
- ☐ Kidney disease
- ☐ Chemical dependency (i.e., alcoholism)
- ☐ Ehlers-danlos syndrome
- ☐ Cancer
- ☐ Inflammatory arthritis (rheumatoid, ankylosing)
- ☐ Stroke
- ☐ Depression
- ☐ Osteoporosis

During the past month, have you been bothered by having little interest or pleasure in doing things?

○ No ○ Yes

Please list all surgeries or other conditions for which you have been hospitalized, including the approximate date and reason for surgery or hospitalization:

Please describe all significant injuries for which you have been treated (including fractures, dislocations, sprains/strains) and the approximate date of injury:

How many:

packs of cigarettes do you smoke a day?: _____ **days per week do you drink alcohol?:** _____

do you drink in an average sitting? (If one drink equals one beer or glass of wine.): **caffeinated coffee or other caffeinated beverage do you drink per day?:**

Please check any of the below that you have experienced in the last 12 months:

- [ ] Weight loss
- [ ] Weight gain
- [ ] Nausea and/or vomiting
- [ ] Fatigue
- [ ] Weakness
- [ ] Fever/Chills/Sweats
- [ ] Numbness or tingling
- [ ] Tremors
- [ ] Seizures
- [ ] Double vision
- [ ] Loss of vision
- [ ] Eye redness
- [ ] Skin rash
- [ ] Problems sleeping
- [ ] Sexual difficulties
- [ ] Night sweats
- [ ] Easy bruising
- [ ] Joint/Muscle swelling
- [ ] Dizziness
- [ ] Excessive bleeding
- [ ] Difficulty breathing
- [ ] Regular cough
- [ ] Arm/Leg swelling
- [ ] Heart racing
- [ ] Difficulty swallowing
- [ ] Heartburn/Indigestion
- [ ] Constipation/Diarrhea
- [ ] Blood in stool
- [ ] Post menopause
- [ ] Problems urinating
- [ ] Urinary incontinence
- [ ] Blood in urine
- [ ] Hearing problems
- [ ] Stress at home or work

Is there anything else about either your history or your current condition that you feel is important to mention?

Signature