Providing services in:
Physical Therapy
Occupational Therapy
Speech/Language Pathology
Aquatic Therapy
Special Therapy Programs

PHYSICAL THERAPY INTAKE FORM

Name: _____ DOB: _____ Age: _____

Marital Status: _____ Children (Ages): _____

Diagnoses: _____ Handedness: Left Right Both

Date of Injury: _____ Date of Surgery: _____

Are you currently working: _____ Full Duty Restricted

Occupation: _____ Main Duties: _____

Medical History

Have you had any X-Rays, MRI's, etc?_____

Results?_____

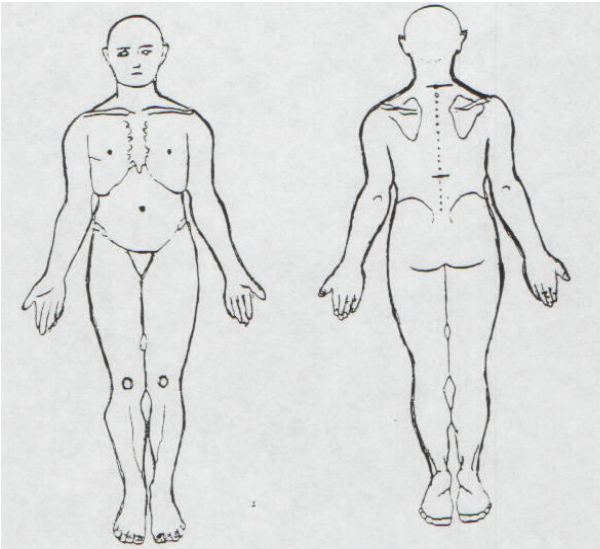
Year	Major medical events (Surgeries Accidents, Illnesses, etc)

Medical History (Check all that apply):

- ❑ Adenoidectomy
- ❑ Allergies
- ❑ Angina
- ❑ Arthritis
- ❑ Asthma
- ❑ Anemia
- ❑ Bleeding Disorder
- ❑ Breast Cancer
- ❑ Bronchitis
- ❑ Cancer/Tumor
- ❑ Coordination Loss
- ❑ COPD
- ❑ Chicken Pox
- ❑ Diabetes
- ❑ Dizziness
- ❑ Eczema
- ❑ Epilepsy/Seizures
- ❑ Encephalitis
- ❑ Glaucoma
- ❑ Gout
- ❑ Headaches
- ❑ Head Trauma (TBI)
- ❑ Hearing Impairments
- ❑ Heart Problems
- ❑ Hepatitis
- ❑ Hernias
- ❑ High Blood Pressure
- ❑ Kidney Problems
- ❑ Lung Problems
- ❑ Mastoiditis
- ❑ Menigitis
- ❑ Mumps
- ❑ Noise exposure
- ❑ Otosclerosis
- ❑ Pneumonia
- ❑ Polio
- ❑ Rheumatoid Arthritis
- ❑ Sinusitis
- ❑ Skin Disease/Cancer
- ❑ Thyroid Disease
- ❑ Tinnitus
- ❑ Tonsillitis
- ❑ Tonsillectomy
- ❑ Tuberculosis
- ❑ Stroke/CVA
- ❑ Systemic Lupus
- ❑ Visual Problems
- ❑ Joint/ Muscle Problems
  - o Foot/Ankle
  - o Knee
  - o Hip
  - o Back
  - o Neck
  - o Shoulder
  - o Elbow
  - o Wrist/Hand

Current Condition

Indicate on the body diagrams where your symptoms are located



How did you become hurt/injured?_____

_____

Are your symptoms: Constant? Intermittent?

Are your symptoms: Getting worse? Getting Better?
Staying the same?

What makes your symptoms better? _____

_____

What makes your symptoms worse? _____

_____

What previous treatments have you had for this condition (chiropractor, surgery)?

_____

What do you hope to accomplish with physical therapy?_____

_____

Do you live alone? Yes No Are you able to drive? Yes No

Do you have a regular exercise program? Yes No

If yes, what types of exercise and how frequently? _____

_____

Therapy History:

Have you had physical therapy in the past? Yes No

What type	Where	Reason	How long

Former therapist's recommendations/conclusions:_____

_____

Medication Name (include prescription, over the counter and supplements/vitamins)	Dosage	Frequency	Route (example. oral, intravenous, subcutaneous, suppository, inhaler, etc.)