PHYSICAL THERAPY INTAKE FORM

NAME _____ DATE _____

OCCUPATION _____ PHYSICIAN_____

LANGUAGE PREFERENCE_____

1.) Please check the postures that make up a majority of your day:

Sitting [ ] Standing [ ] Lifting [ ] Bending [ ] Walking [ ] Kneeling [ ] Child Care [ ] Other _____

2.) HOW did your present pain / problem begin?

_____

3.) WHEN did the problem begin? _____

4.) Have you had surgery / been in the hospital for your problem? Yes ____ No ____ When_____

If yes, surgical procedure_____

5.) Are you presently working? Yes ____ No ____ If not, when was your last day? _____

6.) Over the last 3 days, the area of your body that is the most painful is _____

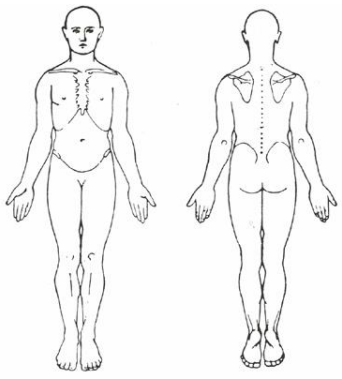
7.) Please check the quality of the pain (check all that apply) Sharp [ ] Dull [ ] Aching [ ] Burning [ ]

Throbbing [ ] Tingling/Numbness [ ] Other _____

8.) Please rate your current pain on a '0' to '10' scale ('0' is NO pain '10' is Worst pain imaginable) : _____

9.) Please mark on the diagram below the areas in which you are experiencing your pain/symptoms.

MARK ON THE DIAGRAM



10.) What activities make the pain worse?

a. Exercising	[ ]	g. Cough/Sneeze	[ ]
b. Sitting	[ ]	h. Worse as the day progresses	[ ]
c. Standing	[ ]	i. Worse in the morning	[ ]
d. Walking	[ ]	j. Lying down	[ ]
e. Bending forward	[ ]	k. Other _____	
f. Bending backward	[ ]	_____	

NAME _____ DATE _____

11.) What reduces your pain?

a. Lying down	[ ]	g. Chiropractic	[ ]
b. Sitting	[ ]	h. Physical Therapy	[ ]
c. Standing	[ ]	i. Nothing	[ ]
d. Walking	[ ]	j. Other _____	
e. Medication	[ ]	_____	
f. Injections	[ ]	_____	

12.) Do you have any troubles with your daily and/or recreational activities? Yes ____ No ____

If yes, please list these activities_____

_____

13.) Are you currently performing any treatment on yourself? Heat [ ] Ice [ ] Stretching [ ] Braces [ ]

Other [ ] _____

14.) Have you had any tests for this problem? CHECK ALL THAT APPLY.

a. X-rays	[ ]	d. Discogram	[ ]
b. CAT scan	[ ]	e. EMG/Nerve Conduction	[ ]
c. MRI scan	[ ]	f. Other_____	

15.) Please list **ALL** current medications (including over the counter meds): _____

_____

16.) Have you recently been in the hospital for other medical problems? Yes _____ No _____

Please specify _____

17.) How would you describe your health? Good _____ Fair _____ Poor _____

18.) What are your goals with Physical Therapy? _____

_____

19.) Do you exercise regularly? Yes _____ No _____ Do you belong to a gym or health club? Yes _____ No _____

Office use only

THERAPIST SIGNATURE_____