PAR PLUS+

PHYSICAL THERAPY INTAKE FORM

NAME _____ DATE _____

OCCUPATION _____ PHYSICIAN_____

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 _____

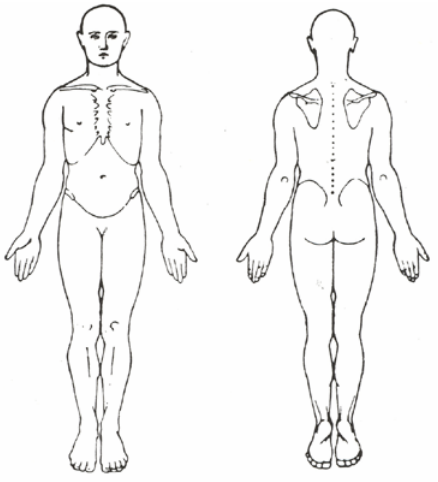
7.) Please check the quality of the pain (check all that apply) Sharp [ ] Dull [ ] Aching [ ] Burning [ ]

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

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_____

PAR PLUS+

HEALTH QUESTIONNAIRE

NAME_____ **DATE**_____

PLEASE READ THIS QUESTIONNAIRE THOROUGHLY. PLEASE CIRCLE OR CHECK OFF THE APPROPRIATE ANSWER. ANSWER ALL THE QUESTIONS.

1. **YES** **NO** ARE YOU HARD OF HEARING?

2. **YES** **NO** HAS YOUR DOCTOR EVER SAID YOUR BLOOD PRESSURE WAS TOO HIGH OR TOO LOW? PLEASE SPECIFY _____ /_____

3. **YES** **NO** ARE YOUR ANKLES OR FEET OFTEN SWOLLEN?

4. **YES** **NO** DO YOU EVER HAVE SPELLS OF DIZZINESS?

5. **YES** **NO** HAVE YOU EVER HAD A SERIOUS INJURY?

6. **YES** **NO** HAVE YOU HAD SURGERY RELATED TO YOUR CURRENT PROBLEM?

   If yes, please describe_____

7. **YES** **NO** DO YOU CURRENTLY SMOKE? If yes, how much? _____

8. **YES** **NO** ARE YOU ON A SPECIAL DIET? Please specify_____

9. **YES** **NO** ARE YOU PREGNANT? (Women only)

10. **YES** **NO** HAVE YOU FALLEN IN THE LAST 3 MONTHS?

11. **YES** **NO** DO YOU CURRENTLY HAVE ANY WOUNDS THAT WON'T HEAL?

12. **DO YOU OR ANY MEMBER OF YOUR IMMEDIATE FAMILY HAVE A HISTORY OF**:

		SELF	FAMILY
A.	GASTROINTESTINAL PROBLEMS.....	( )	( )
B.	HEART CONDITION.....	( )	( )
C.	PACEMAKER.....	( )	( )
D.	ARTHRITIC CONDITION.....	( )	( )
E.	BOWEL/BLADDER DYSFUNCTION.....	( )	( )
F.	UNEXPLAINED WEIGHT LOSS OR GAIN.....	( )	( )
G.	SHORTNESS OF BREATH.....	( )	( )
H.	SEIZURE DISORDER/EPILEPSY.....	( )	( )
I.	SEVERE HEADACHES.....	( )	( )
J.	HYPOGLYCEMIA.....	( )	( )
K.	DIABETES.....	( )	( )
L.	ASTHMA OR RESPIRATORY PROBLEMS.....	( )	( )
M.	STROKE…….	( )	( )
N.	CANCER……	( )	( )
O.	OSTEOPOROSIS……...	( )	( )
P.	TUBERCULOSIS, or HEPATITIS. ……...	( )	( )