

# Physical Therapy Intake Form

## Personal Information

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Email: \_\_\_\_\_  
DOB: \_\_\_\_\_ Sex: \_\_\_\_\_  
Who referred you? \_\_\_\_\_

## 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-Agravating 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



Signature \_\_\_\_\_

Date \_\_\_\_\_