PHYSICAL THERAPY INTAKE FORM

NAME: _____ DOB: _____ HEIGHT: _____ WEIGHT _____

BODY PART INJURED: **RIGHT/LEFT** _____ DATE OF INJURY/ONSET: _____

DIAGNOSTIC TESTS: X-RAY MRI CT EMG/NCV

PRIMARY CARE PROVIDER: _____

HAVE YOU SEEN A SPECIALIST? **YES/NO** NAME: _____

HAVE YOU RECEIVED ANY TREATMENT FOR THIS ISSUE? **YES/NO** _____

PLEASE DESCRIBE ANY PRIOR INJURY TO THIS AREA _____

_____

PLEASE RATE THE LEVEL OF PAIN YOU TYPICALLY EXPERIENCE (0 = NO PAIN, 10 = WORST IMAGINABLE PAIN)

0/10 5/10 10/10

PLEASE LIST ALL MEDICATIONS YOU ARE TAKING: _____

_____

MY EXERCISE ROUTINE INCLUDES: _____

MEDICAL HISTORY

- ☐ HEART DISEASE
- ☐ PERIPHERAL ARTERY DISEASE
- ☐ HEART ATTACK (MI)
- ☐ PACEMAKER/DEFIBRILLATOR
- ☐ NEUROLOGICAL CONDITIONS (MS, STROKE, TBI)
- ☐ DIABETES/ENDOCRINE DISORDERS
- ☐ DVT/BLOOD CLOT
- ☐ LUNG DISEASE (COPD, ASTHMA)
- ☐ CANCER (PLEASE SPECIFY) _____
- ☐ ORTHOPEDIC CONDITIONS (OA, RA, SPRAIN/STRAIN) _____
- ☐ ORTHOPEDIC SURGERIES (TOTAL KNEE/HIP, ARTHROSCOPY)_____
- ☐ OTHER SURGERIES_____

ALLERGIES: ☐ LATEX ☐ ADHESIVE TAPE ☐ MEDICATIONS

SIGNATURE: DATE: