Physical Therapy Intake Form

Date:_____/_____/__________

PATIENT INFORMATION

Name:

Date of Birth (mm/dd/yyyy): / / Gender:

Address:

City: Zip:

Phone (primary): (secondary): Employer:

E-mail:

Emergency contact: Phone: Relationship:

Medical doctor: MD Tel:

Names of other healthcare providers:

How did you hear about Wildwood:

Optimal health is only possible when the physician has a complete understanding of the patient physically, mentally, and emotionally. Your time, thoughtfulness and honesty in completing this confidential overview will greatly assist our understanding of your healthcare needs and desires.

CURRENT ISSUE

What is the problem that brings you to PT?____

When did this problem begin?____

How did it happen? ____

What symptoms did you feel first?____

How did these symptoms progress? ____

Did you receive any treatment for this problem? ____

- How long? ____
- Did it help? ____
- What was done? ____

Overall, is it getting better, worse, or the same? ____

Have you ever had this problem before? ____

Have you had any tests done for this problem? ____

- Results? ____

Any recent unexplained weight loss or gain? ______________________________

____

Does coughing/sneezing bother you? ______________________________

Do you ever have numbness or tingling in both hands or feet? ______________________________

Ever feel clumsy with walking? ______________________________

General Health? Past medical history/surgical history? ______________________________

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MEDICATIONS

Please list all current medications (prescription and over-the-counter), the daily dose and how long you have taken it.

Medication	Dose/day	How long?	Medication	Dose/day	How long?
1			5		
2			6		
3			7		
4			8		

Please list all current vitamins/minerals, herbs, or homeopathics, the daily dose and how long you have taken it.

Supplement	Dose/day	How long?	Supplement	Dose/day	How long?
1			5		
2			6		
3			7		
4			8		

PAIN/SYMPTOM BEHAVIORS

What makes symptoms better? ______________________________

Worse? ______________________________

Amount of activity needed to stir up symptoms? ______________________________

- Severity of symptoms? ______________________________
- How long does it last? ______________________________

Within a 24 hour day, do your symptoms bother you at night?

- In what way? ______________________________
- How are you when you get out of bed? ______________________________
- How are your symptoms as the day goes on? ______________________________

Is there pain anywhere else? ______________________________

Describe how it feels. Is it constant? ______________________________

Do the areas of pain/symptoms seem related to one another? ______________________________

Do you have any areas of numbness or tingling? ______________________________

Is there anything else you think is important that I know about you? ______________________________

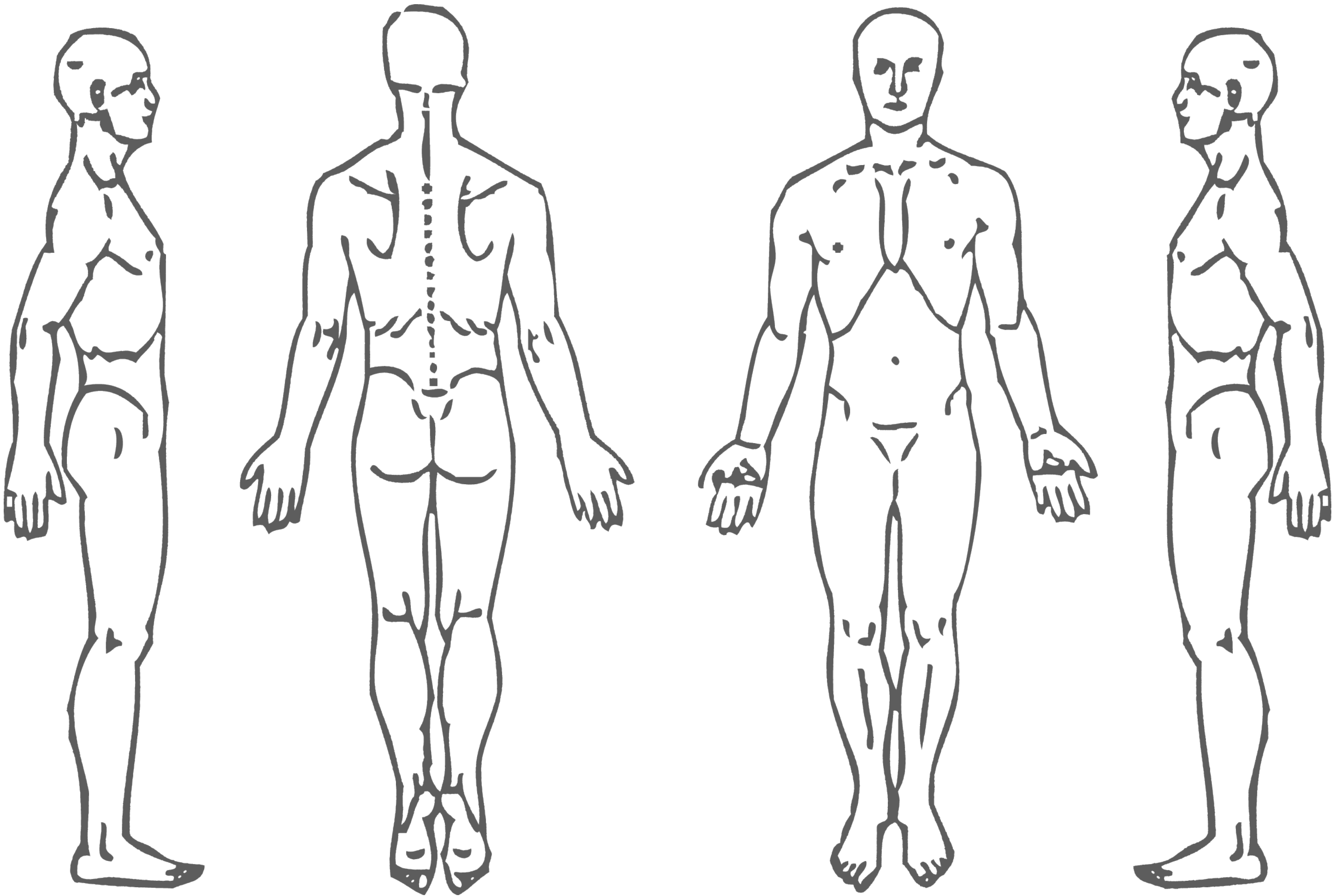
____

VISUAL ANALOG SCALE

Indicate on the line where the pain is in relation to the two extremes:

No Pain I---I Severe Pain

Please circle any areas of symptoms or discomfort:



Thank you very much for taking the time to complete this form.

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