Healing Foundations
Physical Therapy

Patient Intake Form

Name: ______________________________ Date of Birth: __________ Today's Date: __________
Primary Phone: _______________________ Secondary Phone: _______________________
Email Address: ____

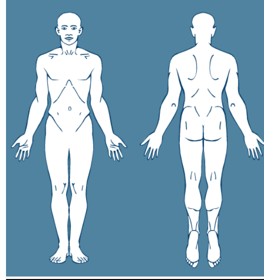
Emergency Contact: ______________________________ Phone: _______________________

Referring Physician: ________________________ Primary Physician: ________________________
Do you have a follow-up appointment with your referring physician? ___Yes Date: __________ No: ___
Is your injury the result of a MVA? ___Yes, Date: __________ ___No State where occurred: _______
****If yes, please provide our office with your auto insurance policy information.**

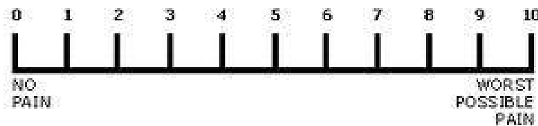
Have you had any other Physical Therapy services within your plan year? ___Yes / ___ No

History

Location of your present symptoms (please indicate them on the diagram):



Please indicate the severity of your pain (within the last week) on the scale:
A = Best **B = Current** **C = Worst**



Date of Injury or Onset of Symptoms: __________ Cause of Injury: ______________________________

Please describe your symptoms:

____

____

____

Frequency of your symptoms (circle best response):
a. Constant - present 24 hours per day

b. Intermittent - symptoms fluctuate depending upon your position or how you are moving

Please indicate the ***percentage of the day*** during which you typically experience symptoms (**circle** the best response):

25% of day 50% of day 75% of day 100% of day

What activities typically ***increase*** your pain or symptoms (**circle** those that apply)?

Bending Sitting Standing Lifting Walking Stairs up/down Sleeping Lying Turning head

A.M. ______ As the day progresses: ______ P.M. ______ When still or while moving?: __________

Other: ____

What activities typically ***decrease*** your pain or symptoms (**circle** those that apply)?

Bending Sitting Standing Lifting Walking Stairs up/down Sleeping Lying Turning head

A.M. ______ As the day progresses: ______ P.M. ______ When still or while moving?: __________

Other: ____

Previous treatment for this condition: ____

List 3 important activities that you cannot or have difficulty doing because of your impairment:

Degree of Difficulty (please indicate)

1. ____ **Mild** **Moderate** **Severe**
2. ____ **Mild** **Moderate** **Severe**
3. ____ **Mild** **Moderate** **Severe**

What are your specific goals for therapy?____

Medical History

Do you experience any of the following along with your current symptoms? (**circle** those that apply):

Dizziness / Tinnitus / Nausea / Difficulty Swallowing / Other: _______________________________

Do you have any pain or difficulty coughing / sneezing/ straining? Yes ____ No ____

How is your bladder functioning? Normally____ Abnormally ____

Please list any medications you are taking: ____

____

How is your general health? Excellent Good Fair Poor

Have you had any recent imaging (date)? X-rays: ______ MRI: _______ CT Scan: __________

Results: ____

Any unexplained weight loss? Yes (how much?) _________________________________ No ____

Please list any recent or major surgeries with dates: _______________________________________

Is there a possibility you are pregnant? Yes (Due date) _________________________ No ____

Any recent accidents or traumatic events? ____

Do you have or have you had any of the following conditions?

Osteoporosis	Yes / No	Cardiac/Heart Problems	Yes / No
High Blood Pressure	Yes / No	Cancer	Yes / No
Pacemaker/Defibrillator	Yes / No		

Is there anything else we should know? Yes ____ No____

I understand that I am responsible to inform the Physical Therapist of any changes to my condition, medical history, allergies or medications I am taking.

_________________________________ _________________________ ______________

Patient Signature **Printed Name** **Date**