Intake Form

Name: **Date:** **Referring Physician:**
Date of Birth: **Occupation:** **Primary Care Physician:**
Insurance Type: **Diagnosis:**

Current Condition(s)/Chief Complaint(s):

Describe the problem(s) for which you seek therapy:_____
_____

When did the problem begin (date)? _____

What Happened/Injury?_____
_____

Have you ever had surgery for this condition? ☐ **Yes** ☐ **No** – If Please describe, and include dates: _____
_____

What is your primary complaint because of the injury/pain: _____

Functional Limitations (check all ☐ that apply):

SELF CARE
Hygiene
Grooming: Brushing ☐
Nail care ☐
Dressing ☐
Bathing ☐
Toileting ☐
Sleep ☐

MOBILITY
Walking ☐
Moving Around Stairs ☐
Running ☐
Jumping ☐

MAINTAINING BODY POSITION
Sitting ☐
Standing ☐
Squatting ☐
Kneeling ☐
Transferring ☐

CARRYING/HANDLING OBJECTS
IADLs
Using phone ☐
Shopping ☐
Food Preparation ☐
House Keeping ☐
Laundry ☐
Driving ☐

Hand/Arm Use
Pulling ☐
Pushing ☐
Reaching ☐
Throwing ☐
Catching ☐

Fine Hand Use
Picking up objects ☐
Grasping objects ☐

Work ☐
Recreation ☐

Pain Assessment:

Where is your pain/problem located: _____

On a scale of 0-10 (0 = no pain & 10 = emergency room pain), Rate your pain at ***worst*** ____, ***current*** ____, ***best*** _____

Quality of Pain: ☐ Sharp ☐ Dull Ache ☐ Burn ☐ Throb ☐ Electrical ☐ Cramping ☐ Numb/Tingling
Is the pain: ☐ Localized ☐ Radiating (If radiating pain, where does it travel to _____)

List all activities that make the condition worse: _____

List all activities that make the condition better: _____

Have you had the problem(s) before? ☐ Yes ☐ No Describe:_____

_____

If yes, how did you treat the problem(s)_____

How frequent would you rate the pain? (Circle one): Constant Frequent Occasional Intermittent

Since the start of pain, have your symptoms: ☐ Improved ☐ Worsened ☐ Remained the same

Medical/Surgical History: Please check if you have ever had (Please check all that apply**):**

☐ Arthritis	☐ Broken Bones	☐ Osteoporosis	☐ Circulation/ Vascular problems
☐ Blood Disorders	☐ Heart Problems	☐ Lung Problems	☐ High Blood Pressure
☐ Coordination problems	☐ Heart palpitation	☐ Shortness of breath	☐ Dizziness/Blackouts
☐ Stroke	☐ Diabetes	☐ High Blood Sugar	☐ Low Blood Sugar
☐ Head Injury	☐ Multiple Sclerosis	☐ Parkinson's Disease	☐ Muscular Dystrophy
☐ Seizures	☐ Depression	☐ Epilepsy	☐ Developmental/Growth problems
☐ Repeated Infections	☐ Cancer	☐ Allergies	☐ Ulcers/Stomach problems
☐ Thyroid Problems	☐ Skin Diseases	☐ Infectious Disease	☐ Kidney Problems
☐ Pacemaker	☐ Metal Implants	☐ Other _____	

PLEASE SEE REVERSE SIDE

Medication:

Are you taking any prescription drugs? ☐ Yes ☐ No **If yes, please list or let us photocopy your list:**

_____

Do you take any nonprescription drugs? (Check all that apply)

_____

Do you have any drug allergies? ☐Yes ☐ No If yes, please specify _____

Other Clinical Tests:

Have you had any of the following tests for this condition (Check all that apply)

☐ X-Ray ☐ MRI ☐ CT Scan ☐ Other_____

Where did you go for the tests? _____

When did you have the tests done? _____

Do you give us permission to obtain a copy of the report(s)? If yes, please *initial* here _____

What are your goals for Physical Therapy? _____

Could you possibly be pregnant? ☐ Yes ☐ No

Have you ever been given a home TENs unit or Back support brace? Yes / No

If not, are you interested in learning more about it or receiving one? Yes / No

Are your currently attending Chiropractic Care or Massage Therapy? (please circle) Yes / No