Patient Demographics and Intake Form

Name: _____ Age: _____

Height: _____ ft. / _____ in. Weight: _____ lbs

Occupation: _____

Employment/Work _____ ____ Full-time ____ Part-Time

Primary Care Physician (PCP): _____

Last seen by PCP: _____ / _____ / _____

Doctor's Diagnosis: _____

Restrictions: _____

Date of Injury _____ / _____ / _____
Describe the Problem (Mechanism of Injury, gradual vs sudden onset)

_____

_____

_____

Is the injury Work Related? _____ Is there an attorney involved? _____
Have you had physical therapy before? If so, what did or did not help?

_____

Are you seeing any other health care providers for this condition? _____

Who? _____

Imaging:
Have you had any test for this condition? _____
Circle: X-Ray, MRI, CAT scan, Bone Scan, Nerve/Muscle Test, Other
Result of Test: _____

Previous Surgeries/Any conditions for which you have been hospitalized for and dates:

In the past month, have you felt depressed, down, or hopeless? _____
In the past month, have you had little interest or pleasure in doing things? _____
Do you currently smoke? _____ How many days/week do you drink alcohol? _____
Are you currently pregnant? _____

Do you exercise regularly? _____ How often? _____
Perceived general health status: (i.e. Excellent, good, fair, bad) _____

Falls:
Have you fallen in the past year? _____ How often? _____

If you have fallen:
Did you sustain an injury? _____ Do you currently take Vitamin D supplements? _____

Medication:
Have you been taking an over-the-counter medication? _____

Which ones? _____

Any other medication taken?(You may provide your own list)

_____

Have you ever been diagnosed with having any of these conditions? Circle or highlight.

Seizuires/Epsilepsy	Asthma	Thyroid Problems	Cancer	Gout
Stroke/TIAs	COPD	Alzheimer's	Vision/Hearing Loss	Endoetrosis
High Blood Pressure	Weight/Energy Loss	Multiple Sclerosis	Sleeping Problems	Tuberculosis
Heart Problems	Pacemaker	Parkinson's	Dehyrdation	HIV/Aids
Circulation Problems	Osteoarthritis	Chemical Dependency	Fractures	Pelvic Inflammatory Disease
Diabetes	Osteoporosis	Anemia	Depression	Hepatitis

Have you recently noted? Circle or highlight.

Significant weight loss/gain
Nausea/Vomiting
Dizziness/Lightheadeness
Fatigue
Excessive weakness
Fever/chills/sweats
Numbness or Tingling
Night Pain

Pain Scale
(On a scale of 1-10, 1 is the worst and 10 is the best)

Current Level of Pain: _____ Worse Level of Pain: _____ Best Level of Pain: _____

What aggravates your symptoms? _____

What alleviates your symptoms? _____

Activities you would like to do but are restricted: _____

What are you expectations or goals for physical therapy?

_____

_____