Outpatient Physical Therapy Medical Intake Form

Name: ______________________________ Male ☐ Female ☐ Height: ______ Weight: ________ bs

Occupation: ______________________________ General Health: Excellent ☐ Good ☐ Fair ☐ Poor ☐

Diet: ______________________________

Exercise: ______________________________

Smoking: ☐ Yes / ☐ No Alcohol: Yes ☐ / ☐ No If yes, how many drinks per day ___ per week ___ occasional ___

Medical conditions: ______________________________

Medications: ______________________________

Assistive Devices: None___ Cane ___ Walker___ Hearing aids___ Glasses___

Other: ______________________________

Past Injuries/Surgeries with dates: ______________________________

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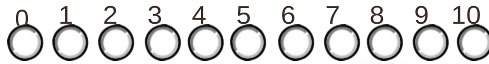
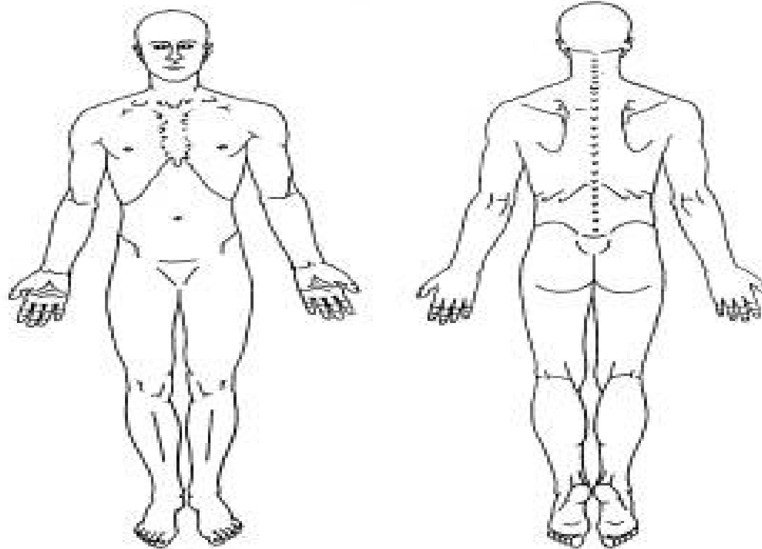
Medical Tests: X-ray___ MRI___ CT scan___ Bone density___ EMG___ Blood test ___ Urinalysis___ Other Tests/Results:

____

Current condition(s)/ symptoms: ______________________________

Pain level in the last couple of days (circle): No pain Mild Moderate Severe





Where is your pain located?

____

How would you describe the pain? ◯ Dull ◯ Achy ◯ Sharp ◯ Numb ◯ Tingling

When did your symptoms start? ________ , ________ , ________

How did your symptoms develop? Injury (explain): ______________________________ date: ____/____/____

Surgery (type):______________________date:___/_____/________ Unknown cause____

Have you received other treatment for your current condition? ☐Yes /☐No

If yes, what type of treatment? _________________________Was it helpful? ☐ Yes /☐No

Have you ever had this condition before?☐Yes / ☐No If yes, when? __________________

Did you receive treatment for prior episodes? ☐ Yes/ No☐

If yes, what type of treatment? __________________________ Was it helpful?☐Yes /☐No

What makes your symptoms worse?____

What eases your symptoms? ____

What are your goals/expectations for physical therapy? ________________________

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