Physical Therapy Options

Physical Therapy History Intake Form

Name: _____

DOB: _____

1. What is your reason for seeking physical therapy?

2. When did your problem begin?

3. How did your problem start?

4. Have you had any testing? MRI, X-ray……..If so, please tell results

Medical History

1. Do you have high blood pressure?
2. Do you have heart problems?
3. Do you have blood sugar issues-diabetes or hypoglycemia?
4. Do you have asthma?
5. Do you have an infection?
6. Do you have osteoporosis?
7. Do you or have you had cancer?
8. Are you or could you be pregnant?
9. Do you have any health problems?
10. Do you have any other health problems? If yes, please list/explain
11. Is there anything your doctor told you not to do?
12. Are you taking any prescription or over the counter drugs?
    Please list:

    _____

    _____

13. Are you taking any supplements or herbs?

    Please list:

    _____

14. Are you allergic to adhesives/tape, latex, or bee stings?
15. Do you have any other allergies-medications, food, etc?
16. Have you ever had physical therapy for anything?
    If so what?

17. Have you had any surgeries? If so, please list.

_____

18. Do you have any metallic implants (ie pacemaker, joint replacements)?

_____

PAIN:

Do you have pain now? Location/Type:

What makes it better?

What makes it worse?

Does the pain interfere with your daily life? No Yes, Describe:

RATE YOUR PAIN ON A SCALE OF 0-10 (0 BEING NO PAIN AND 10 BEING THE WORST) _____/10 Today

What are your goals as a result of attending physical therapy?