Medical Intake Form

Name: ___________________________________ DOB: _________________
Preferred name: ___________________________
Address:
____
Phone Number: ______________________ Email: ________________________________
Primary Care Physician: ____________________ Referring MD: ____________________
Emergency Contact:
Name: _______________________ Address: ___________________________________
Phone Number: __________________________
Why do you want to come to physical therapy?
____
____
____
When/how did your problem start?
____
____
Medications: *please fill out the medication list form*
Have you had physical therapy before? YES/NO
Do you have high blood pressure? YES/NO
Do you have an infection? YES/NO
Do you have diabetes? YES/NO
Do you have cancer? YES/NO
Do you have any metal/implants? YES/NO If yes, where: ________________________
Do you have cardiovascular issues/condition? YES/NO If yes, what:________________
Do you have respiratory issues? YES/NO If yes, what; ___________________________
Do you have osteoporosis? YES/NO
Are you pregnant or could be pregnant? YES/NO
Do you have a disease transferred by bodily fluids? YES/NO If so, what: _____________
Are you immunocompromised? YES/NO
Do you have any other past medical history or health issues? YES/NO If so, what:
____
____
____

Have you had any surgeries? YES/NO If so, what/when:

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____

____

Do you have any allergies? YES/NO If so, please list:

____

____

____

Have you recieved treatment for this problem? YES/NO If so, please list:

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____

____

Have you recived any imaging or tests for this problem? If so, please list:

____

____

____

Do you have an upcoming physician appointment regarding this issue? YES/NO If so, when:

____

Describe your pain.

____

____

____

When do you have pain?

____

____

____

What makes it better?

____

____

____

What makes it worse?

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____

____

What is your pain at best? Worst?

Have you had any falls? If so, when?

Are you afraid of falling? YES/NO

Do you live with anyone? YES/NO If so, who?

Do you have steps? YES/NO Handrail? YES/NO

What are your goals for physical therapy?

WE LOOK FORWARD TO SEEING YOU!

THANK YOU!