



MEDICAL INTAKE FORM

Patient: _____ Primary Care Dr. _____ Date: _____

Occupation / Type of Work: _____

Significant sporting / recreation activities / hobbies : _____

Social History: Whom do you live with? Family Friends Other _____

Have you received physical therapy in the past? Y / N If so, when? _____. For what reason? _____

What is the main reason for this visit? (pain, weakness, etc): _____

When did this issue begin?: _____ Symptom frequency Constant Intermittent Other _____

What can you NOT do because of pain? _____

What activities or positions make your symptoms worse? _____

What activities or positions best relieves your symptoms? _____

Does your pain wake you at night? Y / N Sometimes Is this related to an injury? Y / N Maybe

If so: Date of Injury _____ How did the injury occur? _____

Low back or Neck Patients: Do you have any arm or leg symptoms? Y / N Sometimes

If yes, where? _____

Circle any diagnostic tests you have had.

X-rays MRI CT Scan Myelogram EMG Bone Scan Bone Density Other

MEDICAL INFORMATION: TO THE BEST OF YOUR KNOWLEDGE, DO YOU HAVE / HAVE HAD :

High Blood Pressure	yes	Chest Pains / Angina	yes
High Cholesterol	yes	Pacemaker	yes
Shortness of Breath	yes	Heart Attack	yes
Emphysema	yes	Mitral Valve Prolapse	yes
Diabetes	yes	Blood Clots	yes
Lightheadedness / Dizziness	yes	Bleeding/Bruising	yes
Vertigo	yes	Syncope	yes
Anxiety/Panic Attacks	yes	Arthritis/Joint Pain	yes
Artificial Joints	yes	Thyroid Problems	yes
Polio / Muscle Disease	yes	Seizures	yes
Migraine/Cluster Headaches	yes	TMJ Disorders	yes
Chronic Headaches	yes	Swelling of Extremities	yes
Blurred or Double Vision	yes	Fibromyalgia	yes
Chronic Fatigue Syndrome	yes	Lyme's Disease	yes
Chronic Pain	yes	Unexplained Weight Loss	yes
Cancer/Tumors/Growths	yes	Unexplained Fatigue	yes
History of Smoking	yes	Hypoglycemia	yes
Are you pregnant?	yes	Bladder Incontinence	yes
Bowel Incontinence	yes	Asthma	yes
Hearing Loss or Ringing Ears	yes	Memory Loss	yes
Fractures	yes	Depression	yes
Rash or Itching	yes	Other _____	

List all your past surgeries (for any in the last year, list month and year): _____

List any medications or supplements you are currently taking: _____

List any allergies you have (seasonal, food, medication): _____