



Providing services in:  
Physical Therapy  
Occupational Therapy  
Speech/Language Pathology  
Aquatic Therapy  
Special Therapy Programs

## PHYSICAL THERAPY INTAKE FORM

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Children (Ages): \_\_\_\_\_

Diagnoses: \_\_\_\_\_ Handedness: Left Right Both

Date of Injury: \_\_\_\_\_ Date of Surgery: \_\_\_\_\_

Are you currently working: \_\_\_\_\_  Full Duty  Restricted

Occupation: \_\_\_\_\_ Main Duties: \_\_\_\_\_

### Medical History

Have you had any X-Rays, MRI's, etc? \_\_\_\_\_

Results? \_\_\_\_\_

Medications taking now	Frequency	Reason for taking medication

Year	Major medical events ( Surgeries Accidents, Illnesses, etc)

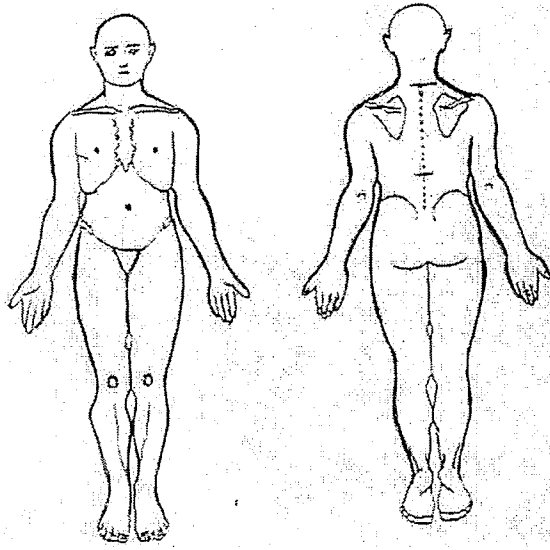
### Medical History (Check all that apply):

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Adenoidectomy<br><input type="checkbox"/> Allergies<br><input type="checkbox"/> Angina<br><input type="checkbox"/> Arthritis<br><input type="checkbox"/> Asthma<br><input type="checkbox"/> Anemia<br><input type="checkbox"/> Bleeding Disorder<br><input type="checkbox"/> Breast Cancer<br><input type="checkbox"/> Bronchitis<br><input type="checkbox"/> Cancer/Tumor<br><input type="checkbox"/> Coordination Loss<br><input type="checkbox"/> COPD<br><input type="checkbox"/> Chicken Pox<br><input type="checkbox"/> Diabetes<br><input type="checkbox"/> Dizziness<br><input type="checkbox"/> Eczema<br><input type="checkbox"/> Epilepsy/Seizures<br><input type="checkbox"/> Encephalitis<br><input type="checkbox"/> Glaucoma | <input type="checkbox"/> Gout<br><input type="checkbox"/> Headaches<br><input type="checkbox"/> Head Trauma (TBI)<br><input type="checkbox"/> Hearing Impairments<br><input type="checkbox"/> Heart Problems<br><input type="checkbox"/> Hepatitis<br><input type="checkbox"/> Hernias<br><input type="checkbox"/> High Blood Pressure<br><input type="checkbox"/> Kidney Problems<br><input type="checkbox"/> Lung Problems<br><input type="checkbox"/> Mastoiditis<br><input type="checkbox"/> Meningitis<br><input type="checkbox"/> Mumps<br><input type="checkbox"/> Noise exposure<br><input type="checkbox"/> Otosclerosis<br><input type="checkbox"/> Pneumonia<br><input type="checkbox"/> Polio<br><input type="checkbox"/> Rheumatoid Arthritis<br><input type="checkbox"/> Sinusitis | <input type="checkbox"/> Skin Disease/Cancer<br><input type="checkbox"/> Thyroid Disease<br><input type="checkbox"/> Tinnitus<br><input type="checkbox"/> Tonsillitis<br><input type="checkbox"/> Tonsillectomy<br><input type="checkbox"/> Tuberculosis<br><input type="checkbox"/> Stroke/CVA<br><input type="checkbox"/> Systemic Lupus<br><input type="checkbox"/> Visual Problems<br><input type="checkbox"/> Joint/ Muscle Problems <ul style="list-style-type: none"> <li><input type="checkbox"/> Foot/Ankle</li> <li><input type="checkbox"/> Knee</li> <li><input type="checkbox"/> Hip</li> <li><input type="checkbox"/> Back</li> <li><input type="checkbox"/> Neck</li> <li><input type="checkbox"/> Shoulder</li> <li><input type="checkbox"/> Elbow</li> <li><input type="checkbox"/> Wrist/Hand</li> </ul> |
|--|--|--|

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**Current Condition**

Indicate on the body diagrams where your symptoms are located



How did you become hurt/injured? \_\_\_\_\_

Are your symptoms:  Constant?  Intermittent?

Are your symptoms:  Getting worse?  Getting Better?  
 Staying the same?

What makes your symptoms better? \_\_\_\_\_

What makes your symptoms worse? \_\_\_\_\_

What previous treatments have you had for this condition (chiropractor, surgery)?

What do you hope to accomplish with physical therapy? \_\_\_\_\_

Do you live alone?      Yes    No                      Are you able to drive?    Yes    No

Do you have a regular exercise program?      Yes    No

If yes, what types of exercise and how frequently? \_\_\_\_\_

**Therapy History:**

Have you had physical therapy in the past?    Yes    No

What type	Where	Reason	How long

Former therapist's recommendations/conclusions: \_\_\_\_\_