Physical Therapy Intake Form

To ensure you receive a complete and thorough evaluation, please provide us with important background information on this form. If you do not understand a question, leave it blank and your physical therapist will assist you. Thank You!

____ **Height** _________ **Weight** ________ **Age** _________

First **MI** **Last**

Are you now or have you within the last 3 months had the assistance of a Home Health Agency? No Yes

Which Agency: __________________ When: __________________

Do you have a pacemaker? No Yes

Treatment received so far for this problem (chiropractic, injections, surgery, etc): ___________________________________

Tell us about your current problem for which you are seeking physical therapy:

When did the problem(s) begin? ____________/_______________
Month Year

What happened?

____

____

____

What activities are you not able to do now that you could do before the problem(s)? Please be as specific as you can; for instance:

______ Turnover in bed	______Sleep through the night
______ Get out of bed	______ Make your bed
______ Ride in a car	______ Pull on sock
_____ Push or pull heavy doors	______ Carry bags of groceries
______ Reach high shelves	______Laundry
______ Move a chair	______ Reach into refrigerator
______ Prolonged standing/sitting	

Other: ____

____

____

Is PAIN the cause of any of these limited functions? No Yes

Explain:

____

____

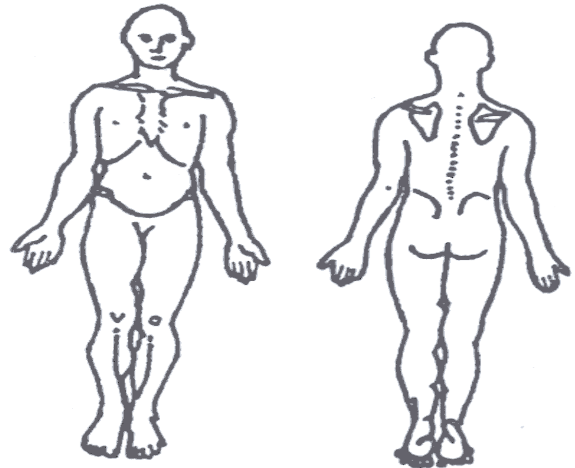
____

Please rate the level of your pain on the following scale.

At present:	0	1	2	3	4	5	6	7	8	9	10
At best:	0	1	2	3	4	5	6	7	8	9	10
At worst:	0	1	2	3	4	5	6	7	8	9	10

(no pain) (moderate pain) (emergency room pain)

Please indicate affected areas by shading these models.



Which of these words describe your symptoms?

Come and go Are Constant

Are constant, but change with activity

(Circle all that apply)

Sharp Dull Burning Aching
Tingling Numb Variable

My symptoms are currently (please circle)

Getting better Getting worse Staying about the same

What positions/activities make your symptoms better?

____

____

What positions/activities make your symptoms worse?

____

____

Employment

Working: _______Full-time ________Part-time ________Volunteer

Where? _________________________ Homemaker ______ Retired

Do you live in?

_____Home _____ Apartment ____________________ Other

With whom do you live?

______ Alone ______Spouse ______ Son / Daughter

Other: ____

Does your home have:

____Stairs, no railing

____Stairs, w/railing

____Ramps

Do you use?

____Cane

____Walker or rollator

____Manual Wheelchair

____Other

General Health

Please rate your health:

____ Excellent ____Good ____Fair ____Poor

Have you had any major life changes during the past Year? (such as a new baby, job change, death of a family member) Yes No

Explain: ____

____

____

Health Habits

Have you fallen recently? ____________

Do you exercise regularly? Yes No

If yes, how often and what type of activities?

____

Medical History:

Have you EVER been diagnosed as having any of the following?

_____ Arthritis: Where? _______________________________

_____Heart disease

_____ High blood pressure

______Osteoporosis/Osteopenia

______Stroke

______ Diabetes

______Cancer: Type: _________________________________

______ Allergies: To what? ____________________________

Other: ____

List your surgeries or other conditions for which you have been hospitalized:

Month/Year

____________________________________ ____/______

____________________________________ ____/______

____________________________________ ____/______

____________________________________ ____/______

Within the past year, have you had any of the following symptoms?

(Check all that apply)

__ General fatigue/weakness

__ Fever/chills/sweats

__ shortness of breath

__ Unexplained weight loss

__ Cognition change

__ Coughing up blood

__ Wheezing

__ Harsh breathing sounds

__ Appetite change

__ Falls

__ Difficulty breathing

__ Heart palpitations

__ Sudden fainting

__ Coughing

__ Swelling in hands/feet

__ Difficulty swallowing

__ Heartburn

__ Specific foot intolerance

__ Dizziness/light headedness

What would you like to gain from Physical Therapy? (Goals)

____

____

____

____

____

Are you attending or receiving any of the following Elder Care services?

_____Daybreak _____Brighter Living

_____Care Management _____Caregiver Support Program

_____ Golden Opportunities

Would you like information regarding any of the services listed above? No Yes, Explain:

____

____