Atlantic
Medicine & Wellness

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Physical Therapy Intake Form

Name: _____ **Date of Birth:** _____ **Today's Date:** _____

Referring Physician: _____ **Address:**_____ **Phone:**_____

Past Medical History (please check):

Are you pregnant?	____ Yes	____No	Osteoporosis	____ Yes	____No
Pacemaker	____ Yes	____No	Blood Clots	____ Yes	____No
Neurologic Disorders	____ Yes	____No	Diabetes	____ Yes	____No
Heart Problems	____ Yes	____No	Cancer	____ Yes	____No
High Blood Pressure	____ Yes	____No	Seizures	____ Yes	____No
Osteoarthritis	____ Yes	____No	Plates or Screws	____ Yes	____No
Joint Replacement	____ Yes	____No	Other:	_____	

Surgery (list type): _____

Any recent health changes? (i.e., significant weight gain/loss, bowel/bladder problems, fever, dizziness; changes in vision and/or speech, etc.)_____

Are you taking any medications? (please list) _____

_____

Allergies to tape/medications? (please list) _____

Do you have difficulty sleeping? If so, why? _____

Did you ever have a Sleep Study performed? _____ **If so, when?**_____ **Results?**_____

What position do you sleep in? _____ **How many pillows do you use?** _____

What are we seeing you for today? _____

Specific date of injury/onset of symptoms (mm/dd/yy): _____

How did it occur? _____

List any previous treatments for this episode: _____

Have you had physical therapy for this problem before? _____

Have you had any of the following tests for this specific incident? ____ CT Scan ____ MRI ____ X-Ray ____ EMG ____ Bone Scan

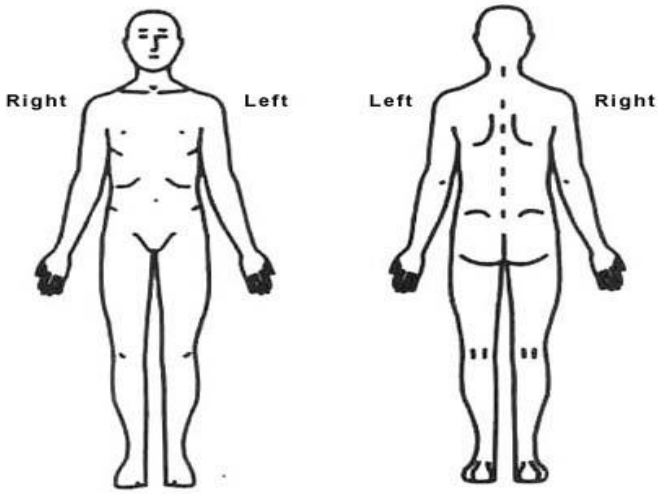
What was your level of activity prior to your injury? (circle one) High Moderate Low

Are you currently being treated by another healthcare provider? ___ Yes ___ No **Who?**_____

When is your next doctor's appointment? _____ **With Whom?** _____

Name: _____ **Date of Birth:** _____ **Today's Date:** _____

Describe your pain and mark areas of pain with an "X" and areas of numbness/tingling with an "O".



My pain is: ____ aching ____ burning ____ stabbing ____ pins & needles
____ dull ____ sharp ____ other: _____

Rate your Pain on a scale of 0-10

0	1	2	3	4	5	6	7	8	9	10
No Pain	**Mild**		**Moderate**		**Severe**		**Intensely Severe**		**Emergency Room**	

Is your pain worse in the **Morning** / **Afternoon** / **Evening** ? (circle one)
Is your pain **Intermittent** / **Frequent** / **Constant** ? (circle one)
What makes your pain worse? _____

What eases your pain? _____

Do you have difficulty with the following tasks?

Getting in/out of Bed	___ Yes ___ No	Climbing Stairs/Curbs	___ Yes ___ No
Dressing/Grooming	___ Yes ___ No	Grocery Shopping	___ Yes ___ No
Housework	___ Yes ___ No	Driving	___ Yes ___ No
Laundry	___ Yes ___ No	Recreational Activity/Sport	___ Yes ___ No
Bending/Standing	___ Yes ___ No	Walking	___ Yes ___ No
Lifting/Carrying	___ Yes ___ No	Standing 30 Minutes	___ Yes ___ No

Other _____

What is your occupation? _____

What does it require?

____ lifting	____ pushing/pulling	____ writing
____ walking	____ computer/typing	____ twisting
____ standing	____ kneeling/crouching	____ carrying
____ standing	____ kneeling/crouching	____ climbing
____ repetitive movements	other:_____	

Who may we thank for referring you to Atlantic Medicine & Wellness? _____

_____ _____ _____ _____
Patient Signature **Date** **Reviewed by Physical Therapist** **Date**