Outpatient Physical Therapy Medical Intake Form

Name: ________________________ Male ☐ Female ☐ Height: ____ Weight: ____ lbs.

Occupation: ____________________ General Health: Excellent☐ Good☐ Fair☐ Poor☐

Diet: _____________________________________

Exercise: ____

Smoking: ☐Yes/☐No Alcohol: ☐Yes/☐No If yes, how many drinks per day ___ per week__ occasional ___

Medical conditions: ____

Medications: ____

Assistive Devices: None ___ Cane ___ Walker ___ Hearing aids ___ Glasses ___

Other: ____

Past Injuries/Surgeries with dates: ____

____

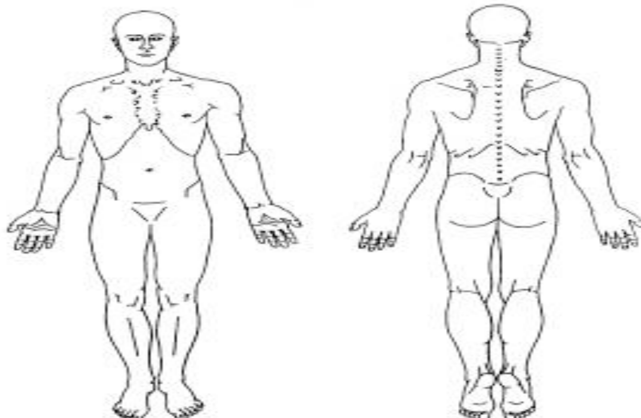
Medical Tests: X-ray ___ MRI ___ CT scan ___ Bone density ___ EMG ___ Blood test ___ Urinalysis ___

Other Tests/Results: ____

Current condition(s)/symptoms: ____

Pain level in the last couple of days (circle): No pain Mild Moderate Severe

0 1 2 3 4 5 6 7 8 9 10
O O O O O O O O O O O



Where is your pain located?

____

How would you describe the pain? O Dull O Achy O Sharp O Numb O Tingling

When did your symptoms start: ______________________________

How did your symptoms develop? Injury (explain): ___________________ date: ___/___/____

Surgery (type): ________________________________date:___/___/____ Unknown cause _________________

Have you received other treatment for your current condition? ☐Yes/☐No

If yes, what type of treatment: _________________________ Was it helpful? ☐Yes/☐No

Have you ever had this condition before? ☐Yes/☐No If yes, when? ________________

Did you receive treatment for prior episodes? ☐Yes/☐No

If yes, what type treatment: ___________________________ Was it helpful? ☐Yes/☐No

What makes your symptoms worse? ____

What eases your symptoms? ____

What are your goals/expectations for physical therapy? _____________________________

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NOTE Please Print & sign this Completed Form