HEALTH POINT
PHYSICAL THERAPY

Physical Therapy Intake Form

Name: _____ **Date:** _____

DOB: _____ **Sex:** Male Female

Address: _____

Phone Number: _____ **Email:** _____

Emergency Contact Name/Phone Number:_____

How did you hear about Health Point?_____

History

Exercise Frequency: _____

Do you smoke? If so, how often? _____

Are you pregnant? _____

Allergies: _____

List of medications: _____

Previous surgeries, if any: _____

Previous diagnosis, if any: _____

Complaint

What is your major complaint? _____

Start date: _____ **Possible cause:** _____

Symptoms: _____

Previous doctors seen in regards to complaint: _____

Previous treatment for this condition:_____

Medications used to relieve pain: _____

Time of day symptoms are worst: _____

Rate current pain (circle choice): No pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain experienced

Duration of pain (circle choice): Seldom Occasionally Constant

Is this your first time seeking treatment for this injury? _____

Do you have any of the following (check all that apply)

- ○ Aids/HIV
- ○ Anemia
- ○ Asthma
- ○ Epilepsy
- ○ High/Low Blood Pressure
- ○ Heart Problems
- ○ Depression
- ○ Multiple Sclerosis
- ○ Liver Problems
- ○ Pacemaker
- ○ Pneumonia
- ○ Arthritis
- ○ Cancer
- ○ Diabetes
- ○ Lung issues
- ○ Stroke
- ○ Seizures
- ○ Fractures
- ○ Osteoporosis
- ○ Frequent Falls
- ○ Other_____

Mark area where pain is located:

Right **Left** **Left** **Right**