

Medical Intake Paperwork



connections
PHYSICAL THERAPY

Name: _____

Date of Birth: _____

Is your injury related to any of the following (please circle if yes):

Auto Related Work Related Other accident related None of the above

If Work Related Only:

Please select your employment status: Full Time Part Time None

Please enter your employer's information:

Employer's Name Address City State

In the event of an emergency, who would you like us to contact?

Name Phone number Relationship

How did you hear about us? Had PT here before Direct Mail Friend/Family
Doctor Referral Google Review Website

Is there an attorney involved with your injury? Yes No

If yes, please provide attorney name and phone number: _____

Are you a Medicare Patient? Yes No

If Yes:

Are you receiving home health now or have you received it in the past 60 days? Yes No

If yes, what is the name of the agency? _____

Have you recently been discharged from home health? Yes No

Please enter date of last home health visit: _____
Date

Medical History

Feet:

Inches

Weight

Date of injury

Physician Diagnosis

How did injury occur?

What region(s) are affected by your current symptoms?

Head/Neck

Upper Back

Shoulder

Arm

Hand/Wrist

Hip

Pelvis

Lower Back

Knee

Leg

Ankle/Foot

Other

If other, please describe

Have you received any previous treatment for this condition?

Yes

No

If yes, please describe

Are you experiencing or have you experience pain associated with this injury?

Yes

No

What kind of pain are you experiencing?

Pain Radiating Down

Pain Radiating Up

Tenderness

Numbness/Tingling

Ache/Pain

None

My symptoms are worse _____.

In the morning

During the day

At night

With activity

At rest

None

Symptoms come and go

Symtoms are constant

My symptoms are best _____.

In the morning

During the day

At night

With activity

At rest

None

Symptoms come and go

Symptoms are constant

Please indicate the intensity of current, best, and worst pain levels over the past 24 hours on a scale of 0 (no pain) to 10 (worst pain imaginable)

Current

0 1 2 3 4 5 6 7 8 9 10

Best

0 1 2 3 4 5 6 7 8 9 10

Worst

0 1 2 3 4 5 6 7 8 9 10

Have you ever had any of the following for this issue before:

Diagnostic tests: Yes / No

 If yes, please describe

Surgery Yes / No

 If yes, please identify date and type of surgery

Other treatment Yes / No

 If yes, please describe

Hospitalization Yes / No

 If yes, please identify hospitalization date

Have you fallen within the last year?

Yes / No

If yes, how many times have you fallen within last year?

Do you feel unsteady when standing or walking?

Yes / No

Do you worry about falling?

Yes / No

Are you a current tobacco user or have you been a user within the last 12 months?

Yes / No

Medical History (cont.)

Please select the conditions that you have been or are presently being treated for. This information helps your therapist develop a treatment plan that will be best for you.

Acquired Respiratory Distress Syndrome	Allergies	Dizzy / Fainting spells	Emphysema
Angina	Anxiety / Panic disorders	Epilepsy or Seizure	Fracture
Arthritis	Asthma	Headaches	Hearing Impairment
Back injury	Bleeding disorders	Heart attack	Hepatitis A, B, C
Bowel / bladder Abnormalities	Cancer	Hernia	High Blood Pressure
COPD	Congestive Heart Failure	HIV / Aids	Hypoglycemia
Defibrillator	Degenerative Disc Disease	Immunosuppressive Meds	Kidney Problems
Depression	Diabetes	Liver / Gallbladder	Metal Implants
Multiple Sclerosis	Nausea / Vomiting	Sexual Dysfunction	Skin Abnormalities
Osteoporosis	Pacemaker	Smoking	Special Diet Guidelines
Parkinson's Disease	Peripheral Vascular Disease	Stroke or TIA	Tuberculosis
Pregnancy	Ringling in Ears	Upper GI Disease	Visual Impairment

Please list any current medications:

Medication	Dosage	Frequency	Route of Administration
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

What are your goals for therapy at this time?

Signature

Date