PHYSICAL THERAPY OUTPATIENT INTAKE FORM

NAME:____ DATE:___________________

MEDICAL HISTORY:

Please circle any past or current medical conditions you may have:

Cardiac Heart Failure	Cancer	Stroke
Pacemaker	High Blood Pressure	Head Injury
Cardiovascular Disease	Diabetes	Neck and Back Pain
COPD	Gout	
Irregular Heart Rate	Arthritis	

Other (please list): ____

Have you had any surgery? Yes No

Please list: ____

Do you have any allergies? Yes No

Please list: ____

Do you have a history of falling?	Yes	No
Do you have dizziness or vertigo?	Yes	No
Do you have balance problems?	Yes	No

Are you taking any medications? Yes No

Please list: ____

NOTE: *If you are currently pregnant or think you might be, please inform your*

CURRENT PROBLEM:

Date of injury or start of condition: ________________________

What happened? Briefly describe your current problem: ____

____

PAIN: On a scale of 0-10, circle the number that best describes the intensity of your pain **right now**.

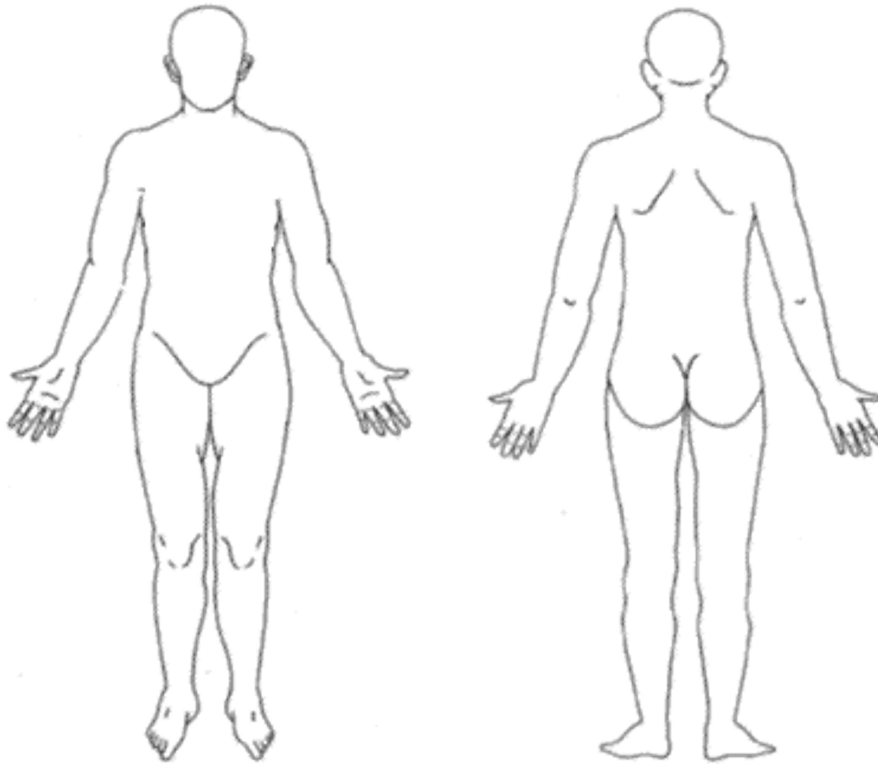
0 = No Pain & 10 = worst pain you can imagine.

0 1 2 3 4 5 6 7 8 9 10

Patient Identification Label

PAIN DRAWING:

Mark the area(s) you are experiencing pain or current symptoms:



The therapist will complete the following questions with you during the evaluation:

Occupation: ____ Currently able to work? Yes No

Recreational activities/hobbies: ____

____

Currently able to perform? Yes No

Patient Goal(s): ____

____

____

Therapist Signature