Core Wellness

& PHYSICAL THERAPY

Outpatient Physical Therapy Medical Intake Form

Name: ______________________________Male___ Female__ÁHeight: ______ 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:____

____

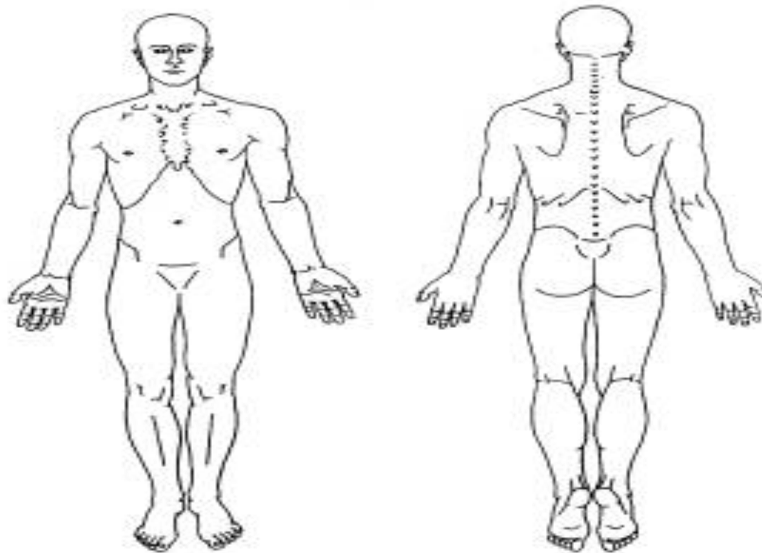
Medical Tests: X-ray___ MRI___CT scan___Bone density___ EMG___Blood test ___Urinalysis___ Other Tests/Results:

____

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



Where is your pain located?

How would you describe the pain? ÁÁDull ÁÁAchy ÁÁSharp ÁÁNumb ÁÁTingling

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? ÁYes /ÁÁÁNo

If yes, what type of treatment? ____________________________Was it helpful? ÁÁÁÁYes /ÁÁÁNo

Have you ever had this condition before? ÁÁÁYes / ÁÁÁÁNo If yes, when? ____________________

Did you receive treatment for prior episodes? Yes/ No

If yes, what type of treatment? ____________________________ Was it helpful? ÁÁÁYes / ÁÁÁNo

What makes your symptoms worse? ____________________________________

What eases your symptoms? ____

What are your goals/expectations for physical therapy?

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