Physical Therapy Existing Patient Intake Form

Patient Name: _____ Today's Date:_____ Date of Birth: _____

Are you currently receiving ANY home health services?: □**Yes** □**No**

Height: _____ Weight: _____

Do you have an adhesive allergy: □**Yes** □**No** Is your injury Work Related: □**Yes** □**No**

Do you have a latex allergy: □**Yes** □**No** Is your injury Auto Related: □**Yes** □**No**

Are you currently taking anticoagulants (i.e. Coumadin, aspirin, Warfarin): □**Yes** □**No**

What kind? _____

Do you regularly exercise? □**Yes** □**No**

If yes, how many hours a week & what activities: _____

What percentage of your work is:

Sitting _____ Standing _____ Manual Labor: _____

Please complete this brief health questionnaire in regards to your current condition:

Chief Complaint: _____

Date of Onset: _____

Describe what caused the pain: _____

Was the Onset: (circle one) Gradual or Sudden Since onset, has it gotten: (circle one) Worse Better Same

Secondary or related complaint (if any): _____

SEVERITY OF PAIN:

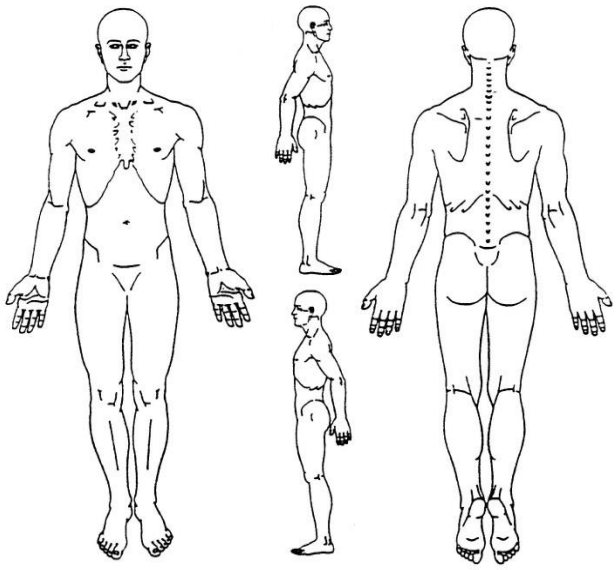
Circle the number which represents the intensity of your pain.

Current Pain Level 0 1 2 3 4 5 6 7 8 9 10

Best Pain Level 0 1 2 3 4 5 6 7 8 9 10

Worst Pain Level 0 1 2 3 4 5 6 7 8 9 10

PLEASE MARK WHERE YOUR PAIN IS LOCATED:



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Does your pain interrupt your sleep:

No difficulty Mild (5-7 Hours of Sleep) Moderate (4-5 Hours of Sleep)
Severe (2-4 Hours of Sleep) Complete (less than 2 Hours of Sleep)

What is your goal for therapy? _____

Falls History

Have you had an injury as a result of a fall in the past year? □Yes □No When:_____

Have you had two or more falls in the past year? □Yes □No Dates of Falls:_____

The information I have given is to the best of my knowledge

_____

Patient or Guardian's Signature **Date**