

MEDICAL INTAKE FORM

effective 1.1.14

Patient: _____ Primary Care Dr. _____ Date: _____

Occupation / Type of Work: _____

Significant sporting / recreation activities / hobbies: _____

Social History: Whom do you live with? Family Friends Other _____

Date of last physical exam _____ Physician seen _____

Have you received physical therapy in the past? Y / N If so, when? _____

For what reason? _____

Height _____ Weight _____

What is the main reason for this visit? (pain, weakness, etc): _____

When did this issue begin?: _____ Symptom frequency Constant Intermittent Other _____

What can you NOT do because of pain? _____

What activities or positions make your symptoms worse? _____

What activities or positions best relieves your symptoms? _____

Does your pain wake you at night? YES / NO / SOMETIMES Is this related to an injury? YES / NO / MAYBE

If so: Date of Injury _____ How did the injury occur? _____

Low back or Neck Patients: Do you have any arm or leg symptoms? YES / NO / SOMETIMES

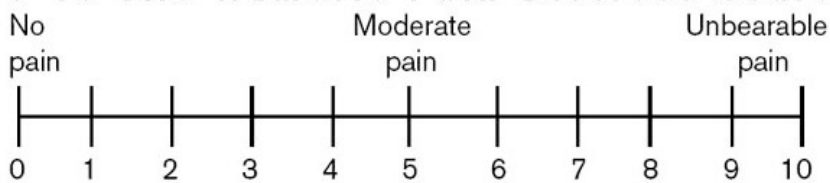
If yes, where? _____

Circle any diagnostic tests you have had.

X-rays MRI CT Scan Myelogram EMG Bone Scan Bone Density Other

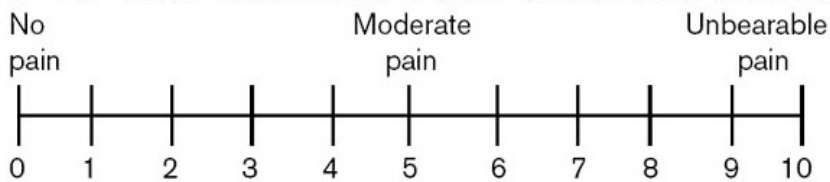
****CURRENT PAIN LEVEL**

0-10 VAS Numeric Pain Distress Scale



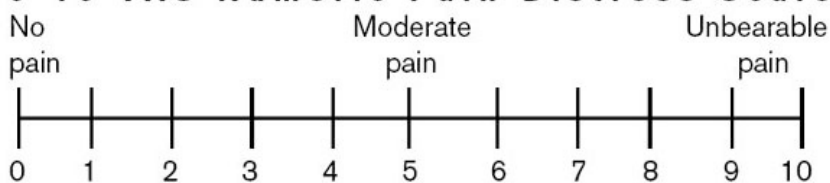
****WORST PAIN LEVEL IN THE LAST 2 WEEKS**

0-10 VAS Numeric Pain Distress Scale

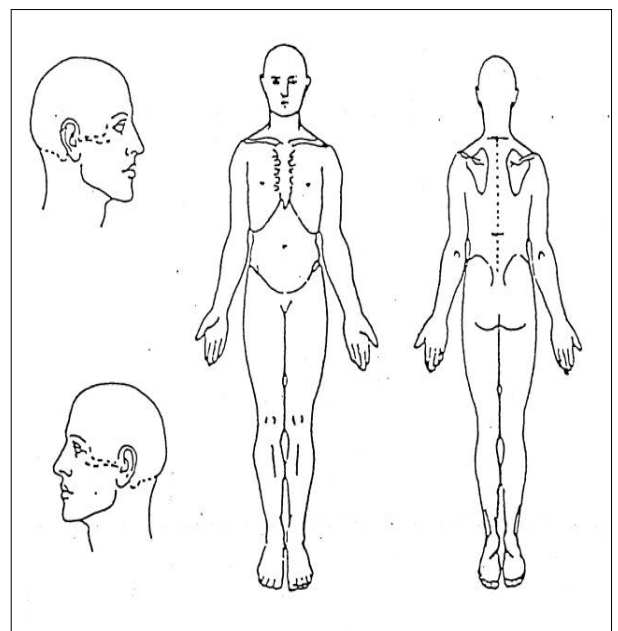


****BEST PAIN LEVEL IN THE PAST 2 WEEKS**

0-10 VAS Numeric Pain Distress Scale



**Indicate where you have pain
or other symptoms**



Are you CURRENTLY seeing any of the following?

MEDICAL DOCTOR YES / NO Reason _____
 OSTEOPATH YES / NO Reason _____
 DENTIST YES / NO Reason _____
 CHIROPRACTOR YES / NO Reason _____
 PSYCHIATRIST / PSYCHOLOGIST YES / NO Reason _____

Have you or any of your family EVER been diagnosed with any of the following? Circle applicable items

Cancer	Heart Problems	High Blood Pressure	Depression
Asthma	Emphysema	Chemical dependency	Hepatitis
Diabetes	Tuberculosis	Thyroid problems	Stroke
Anemia	Kidney Disease	Multiple Sclerosis	Epilepsy
Other	Rheumatoid Arthritis	Other Arthritic Conditions	

Have your had, or do you experience:

CARDIOVASCULAR SYSTEM YES NO

Elevated cholesterol _____
 Sweating associated with pain _____
 Palpitations _____
 Swelling of extremities _____
 History of smoking _____
 Orthopnea (difficulty breathing) _____

G.U. SYSTEM YES NO

Dysuria (painful urination) _____
 Hematuria (blood in urine) _____
 Incontinence _____
 Frequency of Urination _____
 Vaginal Discharge _____
 Dysmenorrhea (painful menstruation) _____
 Post menopause vaginal bleeding _____
 Painful intercourse _____
 Infertility _____
 History of STD _____
 Date of Last Period ____/____/____

GI SYSTEM YES NO

Difficulty swallowing _____
 Heartburn _____
 Jaundice (yellow appearance) _____
 Specific food intolerance _____
 Constipation _____
 Diarrhea _____
 Change in color of stool _____
 Rectal bleeding _____
 Gall bladder problems _____
 Liver Problems _____

PULMONARY SYSTEM YES NO

Dyspnea (labored breathing) _____
 Wheezing _____
 Prolonged cough _____
 Sputum production _____
 amount / color _____ / _____

NEUROLOGICAL SYSTEM YES NO

Ataxia (poor muscular coordination) _____
 Memory lapses _____
 Confusion _____
 Head Trauma _____
 Neurological disorder _____
 Tremors _____
 Slurred speech patterns _____
 Hearing / Visual disturbances _____

ENDOCRINE SYSTEM YES NO

Excessive thirst _____
 Excessive hunger _____
 Polyuria (large volume of urine) _____
 Excessive Sweating _____
 Fatigue _____
 Weakness _____
 Thyroid Problems _____

OTHER SYSTEMS YES NO

ENT (ears, nose, throat) _____
 Integumentary (skin) _____
 Lymphatic _____
 Psychiatric _____
 Musculoskeletal _____

List all your past surgeries (for any in the last year, list month and year): _____

List any medications or supplements you are currently taking (including over the counter) Or attach separate list

Med _____ Dosage _____ Frequency _____	Med _____ Dosage _____ Frequency _____
Med _____ Dosage _____ Frequency _____	Med _____ Dosage _____ Frequency _____
Med _____ Dosage _____ Frequency _____	

List any allergies you have (seasonal, food, medication):