Berryville
Physical Therapy and Wellness

MEDICAL INTAKE FORM

effective 10.31.18

Patient:_____ **Primary Care Dr.**_____**Date**:___/___/_____
DOB ___/___/_____ **Height** _____Ft. _____Inches **Weight** _____Lbs
Occupation / Type of Work: _____**SSN**_____-_____-_____
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 year? YES/NO **If so, when** ___/___/_____
For what reason? _____ **Where?** _____
Did you have home PT? YES/NO When were you discharged? ___/___/_____

What is the main reason for this visit? (pain, weakness, etc):_____
When did this issue begin?: ___/___/_____ Symptoms are □ 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

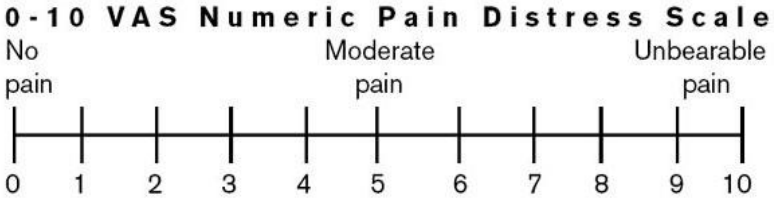
Is this related to an injury? YES/NO/MAYBE **If so: Date of Injury** ___/___/_____ **Details**_____

Worker's Comp? YES/NO **Car Accident?** YES/NO **Date**___/___/_____ **State of Accident** _____

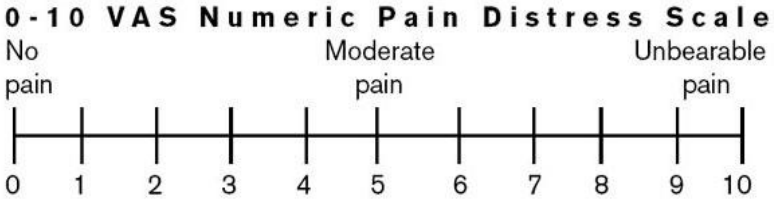
Circle any diagnostic tests you have had.
X-rays MRI CT Scan Myelogram EMG Bone Scan Bone Density Other

Low back or Neck Patients: Do you have any arm or leg symptoms? YES / NO / SOMETIMES
If yes, where? _____

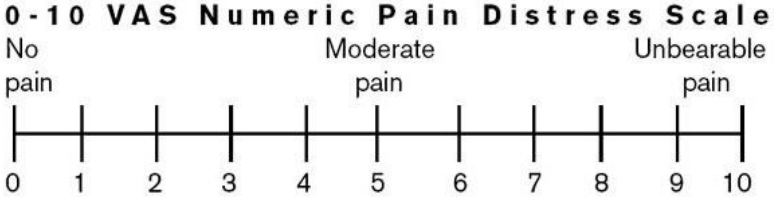
****WORST PAIN LEVEL IN THE LAST 2 WEEKS**



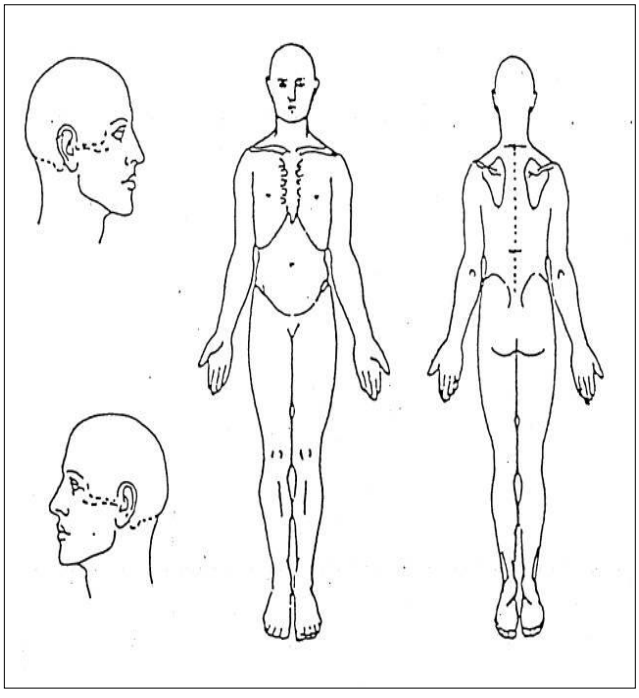
****CURRENT PAIN LEVEL**



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



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 <u>you</u> 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_____ Med _____Dosage_____ Frequency_____

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