Berryville
Physical Therapy and Wellness

LASER THERAPY MEDICAL INTAKE FORM

effective 1.1.18

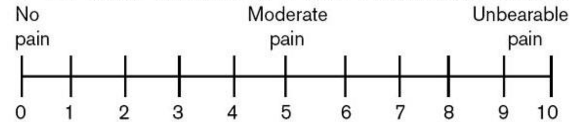
Patient: ____________________________ Primary Care Dr. ________________________Date: ___________
Occupation / Type of Work: ____
Significant sporting / recreation activities / hobbies:____
Have you received physical therapy in the past? Y / N If so, when? __/___/_____ Why? __________________
Height _____________________________ Weight _____________________________

What is the main reason for this visit? (pain, weakness, etc): ____
When did this issue begin?:__________ Symptom frequency ☐ Constant ☐ Intermittent ☐ Other_______
What activities or positions make your symptoms worse?____
What activities or positions make your symptoms better? ____
If this is an injury: **Date of Injury** __________ How did the injury occur?_______________________________
Is your pain worse at night? Y/ N

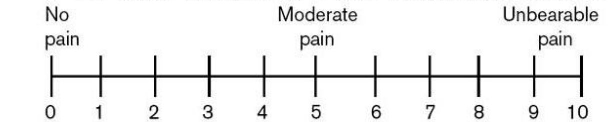
Circle any diagnostic tests you have had.

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

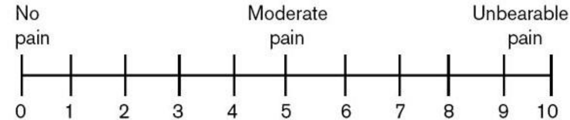
<u>BEST PAIN LEVEL IN THE PAST 2 WEEKS</u>**



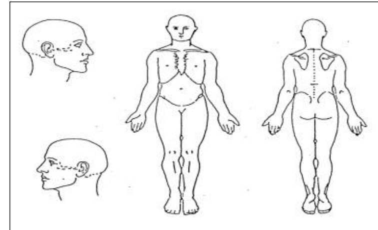
<u>WORST PAIN LEVEL IN THE LAST 2 WEEKS</u>**



<u>CURRENT PAIN LEVEL</u>**



Indicate where you have pain or other symptoms



<u>Please list any medical history, provide details if you have, or have had any problems in the following areas:</u>

HEART PROBLEMS (High BP, High Cholesterol, Heart attack, Stroke, etc.) ____

LUNG PROBLEMS (Sarcoidosis, Emphysema, COPD, Asthma, etc) ____

GI PROBLEMS (Chron’s Disease, Gluten Intolerance, Heartburn, etc) ____

NEUROLOGICAL PROBLEMS (Stroke, Head Injury, MS, ALS, Neuropathy, etc) ______________________________________

ENDORCRINCE PROBLEMS (Thyroid, Diabetes, etc) ____

OTHER HEALTH PROBLEMS ____

SURGICAL HISTORY ____

MEDICATIONS ____

ALLERGIES____