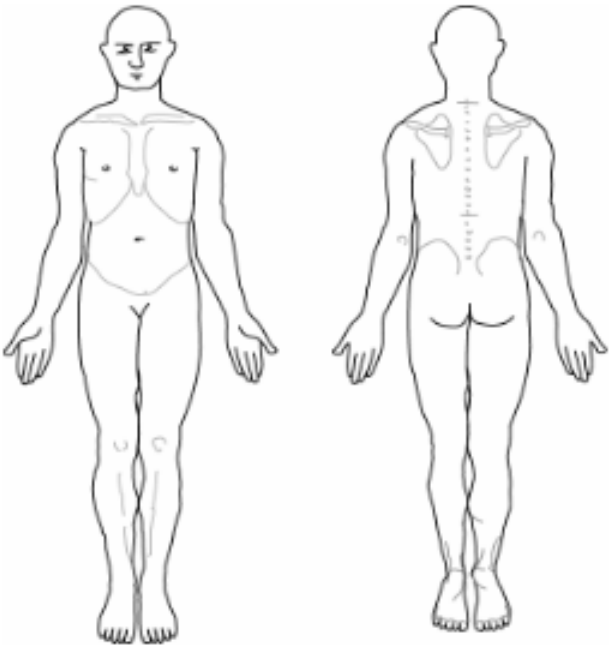
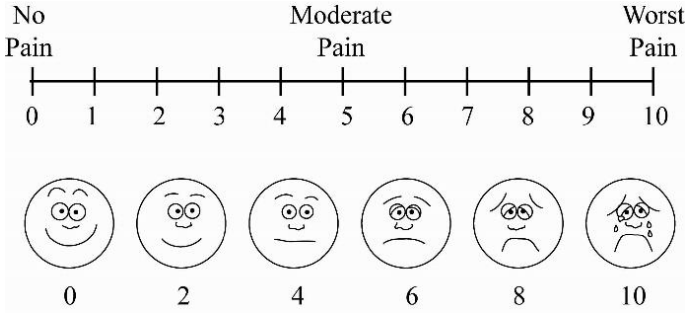
Name: _____ Date: _____

ACHC PHYSICAL THERAPY PATIENT INTAKE

Circle areas of **pain** or **abnormal** sensation on the body chart and rate it on the scale below:





2. When did your symptoms begin? (Please indicate a specific date if possible)

_____

3. Was the **onset** of this episode gradual or sudden? ☐Gradual ☐Sudden

4. How did your problem occur? (Example: a fall, a motor vehicle accident, don't know)

_____

5. Since onset, are your symptoms getting (check one): ☐Better ☐Worse ☐Not Changing

6. Nature of pain/symptoms (check all that apply):
☐ Sharp ☐ Dull ☐ Throbbing ☐ Aching ☐ Occasional ☐ Constant ☐ Shooting
☐ Other_____

7. Does the pain wake you at night? ☐No ☐Yes
If yes, is it present: ☐ While lying still ☐ Only when changing positions ☐ Both

8. Surgeries and/or imaging related to your **current** symptoms

_____

MEDICATIONS

9. Which of the following have you taken in the past week:

	Physician Prescribed
☐ Aspirin	☐YES ☐NO
☐ Tylenol	☐YES ☐NO
☐ Anti-inflammatories (Advil/Motrin/Ibuprofen etc.)	☐YES ☐NO
☐ Stomach ulcer medication	☐YES ☐NO

Anything NOT prescribed by a physician? _____

GENERAL HEALTH

10. How would you rate your general health? ☐ Excellent ☐ Average ☐ Poor ☐ Good ☐ Fair

11. How often do you exercise? ☐ 4-5+ days/wk ☐1-3 days/wk ☐occasional/zero

12. Exercise/Sports/Recreation you do consists of:_____

13. Do you drink caffeinated beverages? ☐No ☐Yes, how many/much per day? _____

14. Do you drink alcoholic beverages? ☐No ☐Yes, how many/much per day? _____

15. Do you smoke cigarettes/cigars/vape? ☐No ☐Yes, how many/much per day? _____

15. What is your current stress level? ☐Low ☐Medium ☐High

FAMILY HISTORY

16. Has anyone in your immediate family (parents, siblings) ever been treated for any of the following?

☐YES ☐NO Diabetes
☐YES ☐NO Cancer
☐YES ☐NO High blood pressure
☐YES ☐NO Psychological condition
☐YES ☐NO Heart Disease
☐YES ☐NO Osteoporosis
☐YES ☐NO Arthritis
☐YES ☐NO Stroke

Other_____