Fisher Physical Therapy

PHYSICAL THERAPY INTAKE

Please complete the entire form

Patient name: _____ **Date:** _____

EMAIL:

HISTORY

Reason for your visit today?
(DIAGNOSIS) _____

Diagnostics	Date of Test	Facility	Results
☐ X-ray			
☐ MRI			
☐ CT Scan			

Medications *Please list ALL medications including over-the-counter and supplements*

Prescriptions	Prescriptions	Over-the-Counter	Supplements

Past Surgical History

Surgery	Year	Hospital	Doctor's Name

Past Medical History *Please check all past or current medical issues that you have received treatment*

☐ Cancer	☐ Osteoarthritis	☐ Loss of Bowel Control	☐ Bleeding Issues	☐ Thyroid
☐ Diabetes	☐ Rheumatoid Arthritis	☐ Loss of Bladder Control	☐ Infections	☐ Liver
☐ Heart Disease	☐ Headaches	☐ Epilepsy or Seizures	☐ Circulatory Issues	☐ Gallbladder
☐ High Blood Pressure	☐ Osteoporosis	☐ Breathing Difficulties	☐ Intestinal Issues	
☐ Stroke	☐ Fibromyalgia	☐ Asthma	☐ Currently Pregnant?	
☐ Pacemaker	☐ Metal Implants	☐ Emphysema or COPD	☐ Other _____	

Balance Disorders or Falls

☐ Falls? When was your last fall? _____
☐ Balance Difficulties?
☐ Vertigo? Details of your last fall: _____

Allergies *Please list any medications or anything else you are allergic or sensitive to*

Allergic To	Reaction

Nutritional History

My eating habits are: ☐ Good ☐ Fair ☐ Poor
Has there been a change in your appetite in the past 6 months? ☐ Yes ☐ No
Have you gained or lost weight (more than 10 pounds) in 1 month without wanting to? ☐ Yes ☐ No
Are you happy with your current weight? ☐ Yes ☐ No
Are you on a special diet? ☐ Yes ☐ No Diet type:

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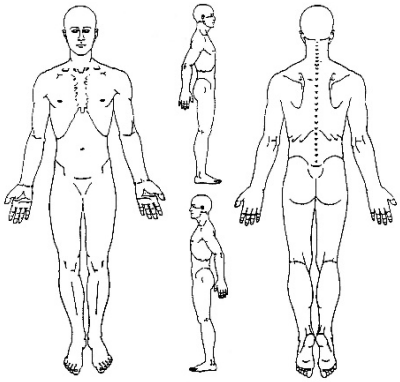
Patient name: _____ **Date:** _____

Pain Assessment *If you answer "No", skip to the next session*

Do you have pain now? ☐ Yes ☐ No If yes, when did it start? _____



Mark with X s where your symptoms are located

Pain Intensity *On a 0-10 scale (0 = no pain, 5 = moderate pain, 10 = very severe pain)*

*Place an **X** on all 3*

Current Pain	Worst Pain	Least Pain
0 5 10	0 5 10	0 5 10

Description

Describe your symptoms: ☐ Aching ☐ Burning ☐ Stabbing ☐ Other

Where do you feel your symptoms? _____

When is your pain the worst? ☐ Morning ☐ Mid-day ☐ Evening ☐ Night

What causes your pain to increase? _____

What causes your pain to decrease? _____

Other Descriptions *Please mark any appropriate descriptions of your symptoms*

☐ Numbness ☐ Tingling ☐ Pins ☐ Needles ☐ Limb falls asleep
☐ Sleep changes ☐ Nausea ☐ Appetite Changes ☐ Depression ☐ Irritable

Since your pain began, are you ☐ Getting better ☐ Staying the same ☐ Getting worse

What everyday activities are limited or changed due to your symptoms?
☐ Care for self ☐ Work ☐ Care for home ☐ Driving ☐ Exercise

Other Treatments *Please mark any treatments that you have tried in the past*

☐ Physical Therapy ☐ Pain Management ☐ Massage ☐ Accupuncture

☐ Heat ☐ Cold ☐ Chiropractic ☐ Other _____

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Patient name: _____ **Date:** _____

General Personal Information / Social History

Hand dominance: ☐ Right ☐ Left

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Do you take care of young children? ☐ Yes ☐ No If "yes", age(s) of children _____

Are you the sole person at home responsible for:

☐ cooking? ☐ laundry? ☐ cleaning? ☐ shopping? ☐ home financials?

Occupation

Are you currently employed? ☐ Yes ☐ No Job Title While Working? _____

☐ Retired When did you retire? _____

Work status: ☐ N/A ☐ Full Duty

☐ Off work due to current injury If so, since when? _____

☐ Working with restrictions Restrictions? _____

Home Environment

I live in a(n): ☐ 1-story house ☐ 2-story house ☐ Apartment ☐ Mobile Home

I live: ☐ Alone ☐ With my spouse ☐ With my children ☐ With a roommate

☐ With a significant other ☐ With my parents ☐ With a caregiver ☐ Other

Do you take care of anyone else (elderly parent, spouse, disabled child)? Who? _____

☐ Yes ☐ No ☐ Full time ☐ Part time

Number of steps to enter house? _____ Going up, railing is on: ☐ Right ☐ Left ☐ None

Is your home modified to help you? ☐ Yes ☐ No If "yes" ☐ Elevated toilet ☐ Bedside commode ☐ Shower chair ☐ Shower bench ☐ Grab bars ☐ Ramp

I currently use a: ☐ Walker ☐ Rolling Walker ☐ Cane ☐ Crutches ☐ Brace/Splint

Recreation

Do you participate in sports? ☐ Yes ☐ No If "yes", what sport? _____

Do you exercise regularly? ☐ Yes ☐ No If "yes", how many days a week? _____

Exercise equipment at home: ☐ Treadmill ☐ Stationary Bike ☐ Pedal Bike ☐ Hand Weights ☐ Pool ☐ Other _____

Hobbies: _____

Habits

Overall, you would describe you sleep as: ☐ Good ☐ Fair ☐ Poor # of hours of sleep _____

# of times getting up _____ Severe pain at night waking you? ☐ Yes ☐ No

Do you currently smoke? ☐ Yes ☐ No # packs per day? _____ When did you start? _____

Do you drink alcohol? ☐ Yes ☐ No If "yes", do you feel you drink too much? ☐ Yes ☐ No