Family Care Plus Physical Therapy & Wellness

Patient intake form

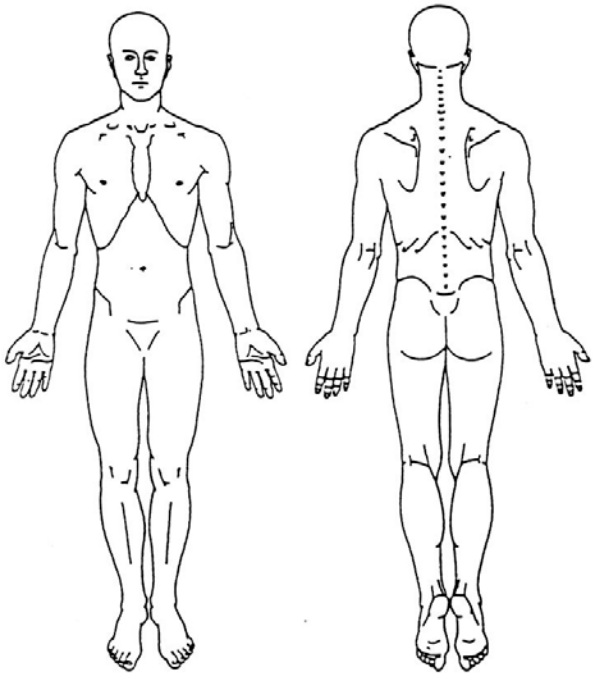
Updated February 2015

Name: _____ Date: _____

Occupation: _____ Are you currently working? ☐ Yes ☐ No

Please indicate when you had first noticed your current condition: _____

Please indicate on the body diagram your signs & symptoms related to your current condition.



Please mark:
X = for pain
O = for tingling
// = for numbness

Also, feel free to add any comments you have:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Is your pain: ☐ Constant (present 24 hours) or ☐ Pain comes and goes (intermittent pain)

Do you have pain at night? ☐ Yes ☐ No

What helps to relieve your pain or symptoms? ☐ Medicine ☐ Rest ☐ Other: _____

How much medicine do you have to take to get relief? _____

List the top 3 activities, which you are unable to do or have difficulty with due to your current condition:

☐ _____
☐ _____
☐ _____

List of all the doctors involved with your care: _____
_____

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Have you had any therapy for your current condition? ☐ Yes ☐ No
If yes, where and how long did you receive therapy? _____

Are you allergic to latex? ☐ Yes ☐ No
Do you smoke? ☐ Yes ☐ No
*Are you pregnant? (For female patients) ☐ Yes ☐ No

Medical History: Check (X)

	Yes	No		Yes	No
Epilepsy			Amputation		
Diabetes			Vision Impairment		
Heart problems			Hearing Impairment		
Pacemaker			Hemophilia/bleeding issues		
High Blood Pressure			Asthma		
Stroke			Emphysema		
Carpal Tunnel			Polio		
Multiple Sclerosis			Cancer		
Cerebral Palsy			Arthritis		

Other medical conditions not mentioned above: _____

Surgical history: List all surgeries that pertain to your current condition or any major surgeries you have had.

Type of surgery	Date of surgery
_____	_____
_____	_____
_____	_____
_____	_____

List of medications including joint injections and pain patches you have:

_____
_____
_____
_____

Please specify if any legal issues/litigations involved with your current/past physical disability:

_____

Any other comments and information: _____
_____
_____