Medical Intake Form

Patient Name_____ Age_____ Occupation_____ Today's Date_____

Physician:_____ Next Doctor's Appointment_____

Current Problem or Injury:

Reason for visit_____ Onset Date_____

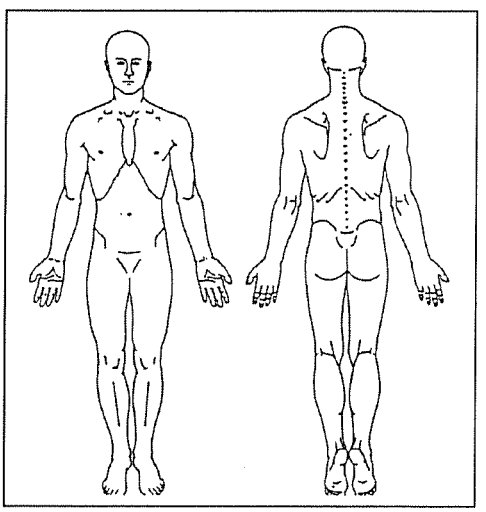
Describe injury or what started problem _____

Have you had: ___X-rays ___MRI ____CT Scan ____Other_____

Surgeries and previous treatments for current problem_____

	No Pain		Mild		Moderate			High		Severe	Unbearable
Pain At Rest	0	1	2	3	4	5	6	7	8	9	10
Pain With Activity	0	1	2	3	4	5	6	7	8	9	10

Mark areas of pain or symptoms on the diagram with an X



Pain is (circle all that apply) Sharp Dull Burning Electrical Cramping

Pain is _____Getting better _____Staying the same _____Getting worse

What increases pain?_____

What decreases pain?_____

Goals for physical therapy_____

Recreational Activities/Hobbies_____

Medical History:

Current Medications_____

_____

_____

Previous Surgeries & Injuries_____

_____

Drug or Latex Allergies_____

Medical History (check all that apply)

____Cancer	____Heart Problems	____High Blood Pressure	____Asthma
____Diabetes	____Arthritis	____Depression / Anxiety	____Headaches
____Stroke	____Seizures	____Dizziness	____Trouble Sleeping
____Pacemaker	____Tingling/Numbness	____Tobacco Use	____Currently Pregnant

Other medical conditions_____