Patient Intake Today's Date____________________

Name:____ DOB:_______________Age:_________

Address:____Phone: ________________________

Sex: **M** **F** Height:___'_____" Weight:_______ lbs Are you **Right** or **Left** handed?

Please describe your reason for Physical Therapy: ____

____

Onset date of this condition:____________________________

How did your symptoms start?____

____

____

What symptoms are you having now?____

____

____

Is this work related? **Yes** or **No** Is this auto related? **Yes** or **No**

Since the onset of your symptoms, have they___worsened___lessened___haven't changed

Are your symptoms: **Constant** or **Intermittent**

What aggravates or worsens your symptoms (i.e. walking, sitting, etc.):________________________

____

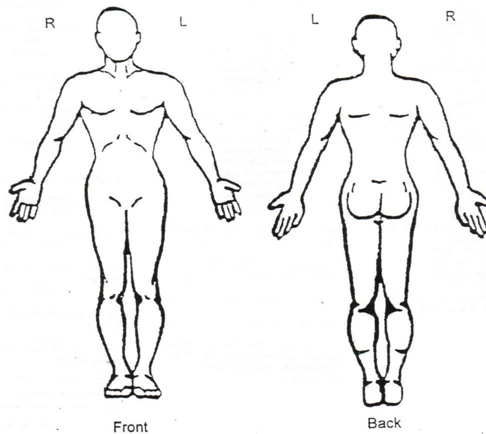
What lessens your symptoms?____

____

Have you had these symptoms in the past? **Yes** or **No** If Yes, when?_________________________

Have you had any Physical Therapy in this calendar year? **Yes** or **No**

Have you been treated for these symptoms elsewhere? **Yes** or **No** If Yes, where?___________________



Please mark the location of your pain on the diagram.

Please rate your pain on a 0-10 scale. (0 is no pain, 10 is excruciating)

Current:_____________ Best:_______________ Worst:______________

Please circle the word(s) that best describe your pain: (all that apply)

Dull Achy Sharp Burning Numb Tingling Tight Other:_______________

What diagnostic tests have you had? (circle all that apply)

X-ray MRI CT scan Myelogram Bone scan

Other diagnostic tests:____

Please list **ALL** medications with dosages, supplements and vitamins you currently take (or provide a list)._______

____

____

____

Please list any allergies:____

Please list all previous surgeries:____

____

____

Please list other injuries you have had requiring medical attention:____

____

____

Please circle any condition that applies to you:

High Blood Pressure	Asthma	Pacemaker
High Cholesterol	Dizzy Spells	Hearing Impairment
Stroke	Seizures	Visual Impairment
Heart Disorders	Diabetes	Bowel or Bladder Problems
Blood Clots	Arthritis	Cancer
Respiratory Disorder	Circulation Disorder	Osteoporosis

Other Conditions:____

(Females) Are you pregnant? **Yes** or **No**

Do you smoke? **Yes** or **No**

Do you have any open wounds? **Yes** or **No** If yes, where?______________________________

Do you have any metal in your body? **Yes** or **No** If yes, where?______________________________

Are you currently receiving psychosocial services? **Yes** or **No**

Do you want us to help you find a source for psychosocial services? **Yes** or **No**

What are your goals for Physical Therapy?____

____

The Referring Physician for Physical Therapy:____

Your Primary Care Physician:____

Emergency Contact:_________________________ Relationship:________________Phone: ______________

By signing below,

I consent to treatment at Leelanau Physical Therapy (or treatment of a child if signing as a parent/guardian) I acknowledge the health and personal information above is true to the best of my knowledge.

Printed Name:______________________________________Signature:________________________________

Date:______________________________

I have reviewed the above information with this patient. ________________________________

Therapist sign/date