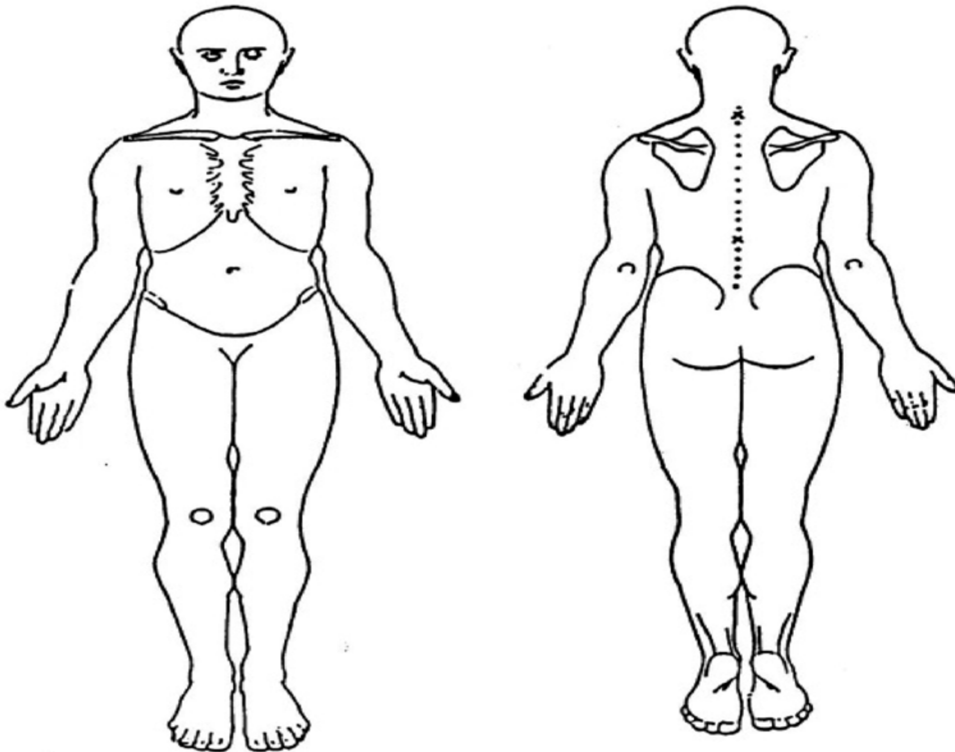
Fyzical

Medical Intake Form

NAME ____ **DATE** _______________

PRESENT CONDITION: PAIN / TENSION

Please place an “X” in the area or areas where you are experiencing pain/symptoms.



Pleas circle the words that best describe your pain.

SEVERE	**DULL**	**STABBING**	**MODERATE**
BURNING	**NUMBNESS / TINGLING**	**THROBBING**	**WEAKNESS**
SHARP	**RADIATING**		

Please rate your pain from 0 (no pain) to 10 (worst imaginable pain) at

Worst	0 1 2 3 4 5 6 7 8 9 10
Now	0 1 2 3 4 5 6 7 8 9 10
Best	0 1 2 3 4 5 6 7 8 9 10

Date of injury onset ____________________________________

What initially caused your pain?____

____

Since it has started, has the pain changed? **Yes** ______ **No** ______

Have your symptoms become **Worse** ______ **Better** ______ **The Same** ______

How often do you experience the pain? ____

What makes your symptoms worse?

Sitting ______ **Standing** ______ **Lifting** ______ **Bending** ______

How much does your pain/problem interfere with your **Daily Activities**?

None 20% 40% 60% 80% 100% of the day.

Have you had any diagnostic tests related to this problem? (I.e., MRI or X-Rays)

Please Specify Where and When____

Have you had any Physical Therapy in the past 12 months for this or any other problem?
Yes _____ No _____

If Yes, Where?
____________________________________When?____________________________________

Have you had a related surgery? **Yes** ______ **No** ______

If yes, what was the date? ____________________________

PAST MEDICAL HISTORY

Do you have, or have you had, any of the following?

☐ Anemia
☐ Allergies
☐ Asthma
☐ Balance
☐ Back Pain
☐ Bowel / Bladder Issues (Incontinence)
☐ Cancer
☐ Chest Pains
☐ Depression
☐ Diabetes
☐ Disc Problems
☐ Headaches
☐ Dizziness / Fainting
☐ Epilepsy
☐ Excessive Fatigue
☐ Fever, Higher than 100 Degrees F
☐ Heart Attack
☐ Heart Disease
☐ High Blood Pressure
☐ Hypoglycemia
☐ Infectious Disease
☐ Knee Pain
☐ Kidney Problems
☐ Liver / Gallbladder Problems
☐ Low Blood Pressure
☐ Low Exercise Level
☐ Metal Implants
☐ Nausea / Vomiting
☐ Neck Pain
☐ Neck Stiffness
☐ Open Wounds
☐ Osteoarthritis
☐ Osteoporosis
☐ Pacemaker or Defibrillator
☐ Perforated Ear Drums
☐ Radiation Treatment within the last 3 months
☐ Rheumatoid Arthritis
☐ Ringing In Ears
☐ Seizures
☐ Shortness Of Breath/Difficulty Breathing
☐ Skin Rashes
☐ Stomach or Intestinal Issues
☐ Stroke
☐ Thyroid Problems
☐ Tingling In Arms / Hands
☐ Tingling In Legs / Feet
☐ Typhoid/cholera/dysentery
☐ Vision Problems
☐ Seizures
☐ Other Health Issues (please explain)

____

____

____

Are you taking any medication? **Yes** _______ **No** _______

If yes, please list medications____

WORK

Are you currently working? **Yes** _______ **No** _______

If yes, how many hours a week? ________________________________

What is your occupation? ____

Please describe what you do at your job ____

____

Patient's Signature ____ Date _____________