Patient Registration | BACK TO ACTION PHYSICAL THERAPY PLC | Waitsfield Vermont

PHYSICAL INTAKE FORM

Name: ______________________ Date of Birth: _____________ Date: ________________

Which area of the body is your chief complaint?_______________________________________

Were you referred to physical therapy by a doctor (circle one)? Yes No

If yes, doctor's name:__________________________ Phone: ______________________

Date of next visit with referring physician:_____________________________________

Have you had any x-rays or diagnostic testing regarding this condition (please list):___________

____

Briefly describe when you have pain; or the most painful activities that you would like to do without pain:____

____

HEALTH HISTORY: Do you have or have you had any of the following (check one column for each question):

	YES	NO	
Allergies	____	____	Allergic to: ______________________
Coronary Heart Disease	____	____	Do you take nitroglycerin? Yes No
High Blood Pressure	____	____	
Diabetes	____	____	
Cancer	____	____	If yes, where/type?_______________
Unexplained weight loss/gain	____	____	

PAIN:

Do you have any waking night pain? Yes_____ No_____ If yes, how many times a night? ___

My pain is (circle one): constant or intermittent

Please rate your pain on a scale from one to ten where 0 is no pain, 1-3 is mild pain, 4-7 is moderate pain, 8-10 is severe pain): 0 1 2 3 4 5 6 7 8 9 10

Have you had any accidents (please explain): ☐ No accidents since last visit

____

____

Please list all surgeries that you have had: ☐ No surgeries since last visit

____

____

List any prescription medication that you are taking: ☐ No change since last visit

____

____

Signature: ___________________________________ **Date:** _________________

Hours: 8:00 a.m. to 5:00 p.m. Monday through Friday