Therapies 4 Kids
Exceptional Care For Exceptional Children

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PHYSICAL THERAPY INITIAL INTAKE FORM

PATIENT INFORMATION

First Name: _____ Occupation: _____

Last Name: _____ Employed? ☐ Yes ☐ No

Date of Birth: ___ / ___ / _____ Age: _____ Employer: _____

Height: _____ (ft., in.) Weight: _____ (lbs) Phone: _____ ☐ Home ☐ Cell

REHAB INFORMATION

Chief Complaint/Ailment/Injury: _____

Date of Injury: _____ Date of Surgery: _____

Briefly describe how you were injured: _____

_____

_____

Have you received therapy for this condition? ☐ Yes ☐ No When? _____ How many visits? _____

Are your symptoms: ☐ Permanent ☐ Intermittent

Mark the number that best corresponds to your pain:

At best: **1 2 3 4 5 6 7 8 9 10** (excruciating pain)

At worse: **1 2 3 4 5 6 7 8 9 10** (excruciating pain)

What decreases/make your condition better? (mark all that apply)

- ☐ Bending
- ☐ Sitting
- ☐ Rising
- ☐ Changing positions
- ☐ Movement
- ☐ Standing
- ☐ Walking
- ☐ Lying
- ☐ Rest
- ☐ Heat
- ☐ Ice
- ☐ Medication
- ☐ Better in AM
- ☐ Better as day progresses
- ☐ Better in PM
- ☐ N/A Cast just removed

What increases/make your condition worse? (mark all that apply)

- ☐ Bending
- ☐ Sitting
- ☐ Rising
- ☐ Prolonged positioning
- ☐ Worse as day progresses
- ☐ Movement
- ☐ Standing
- ☐ Walking
- ☐ Lying
- ☐ N/A Cast just removed
- ☐ Rest
- ☐ Stairs
- ☐ Cough
- ☐ Worse in AM
- ☐ Sneeze
- ☐ Deep breath
- ☐ Medication
- ☐ Worse in PM

Previous medical intervention (mark all that apply)

☐ X-Ray ☐ MRI ☐ Catscan ☐ Injections Other: _____

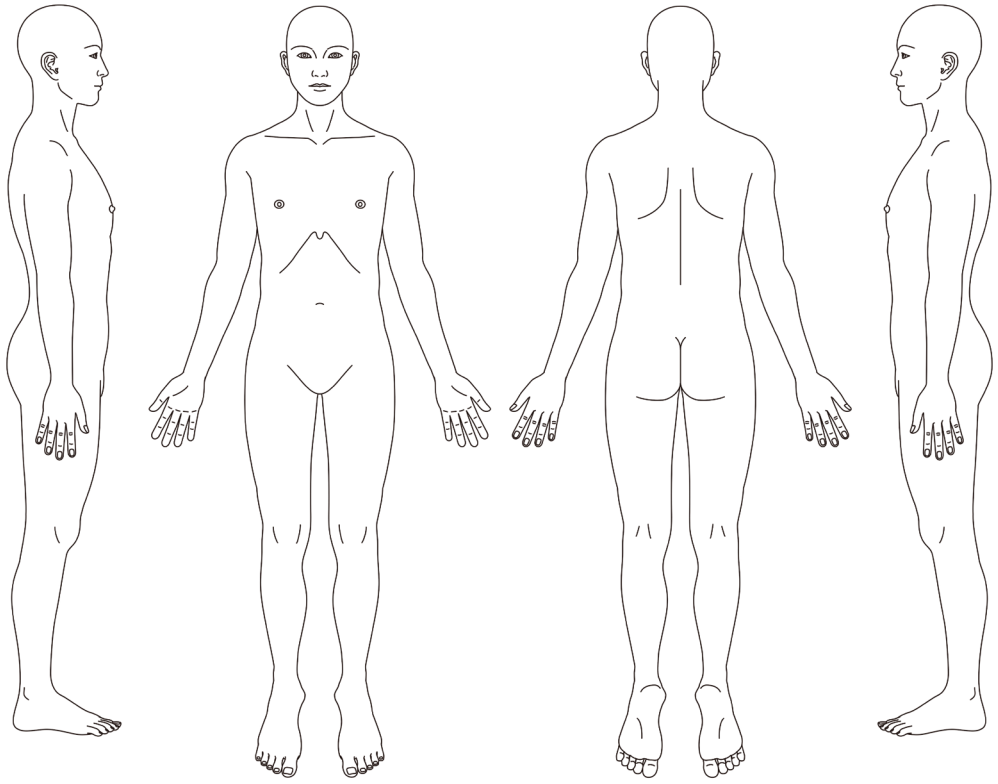
What are your goals to be achieved by the end of therapy? _____

_____

_____

AREAS OF PAIN

Draw in areas of pain on body diagrams using appropriate symbols. If you are completing this form on the computer, print form after completion and mark the diagram with a pen.



Severe pain: *****
Moderate pain: OOOOO
Dull ache: ∩∩∩∩∩
Radiating pain: ↑↓↑↓↑↓↑↓
Numbness/tingling: XXXXXX

MEDICAL INFORMATION

This information is confidential and remains part of your chart. (mark all that apply)

- ☐ Difficulty swallowing
- ☐ Fever/Chills/Sweat
- ☐ Anemia
- ☐ Pacemaker
- ☐ History of smoking
- ☐ Depression/Anxiety
- ☐ Cancer
- ☐ Motion sickness
- ☐ Osteoporosis
- ☐ Heart trouble
- ☐ Shortness of breath
- ☐ History of alcohol abuse
- ☐ Myofascial pain
- ☐ Stroke
- ☐ High blood pressure
- ☐ Blood clots
- ☐ HIV/Hepatitis
- ☐ History of drug abuse
- ☐ Fibromyalgia
- ☐ Arthritis
- ☐ Unexplained weight loss
- ☐ Bleeding problems
- ☐ Epilepsy/Seizures
- ☐ Diabetes
- ☐ Pregnancy

Previous surgeries: _____

Other: _____

Medications: _____

_____

_____

_____

Allergies: _____

_____

_____

_____

Office Use

Date: ___ / ___ / _____ Patient #: _____ Provider: _____