QUALITY PHYSICAL THERAPY LLC

Medical Intake Form

Name:_______________________________________ Date of onset of symptoms:_________
List medications currently taking:____

List any test(s) for this problem:____
If female, are you pregnant? Yes No
Name of doctor who sent you to therapy:____

Do you have any past or present history of: (List, even if controlled with medication)	YES	NO
Heart disease, high blood pressure, angina, pacemaker?	____	____
Respiratory Problems, asthma, allergies, TB?	____	____
Diabetes (any type)?	____	____
Arthritis (diagnosed by MD)?	____	____
Bone disease(s)?	____	____
Skin Disorders, Eczema, Psoriasis, athlete's foot?	____	____
Communicable diseases, hepatitis, TB?	____	____
History of cancer (any type)?	____	____
Any metal or artificial implants?	____	____
Any previous injuries to the same area?	____	____
Any previous surgeries?	____	____
Any history of seizures or epilepsy?	____	____
Do you have a latex allergy?	____	____

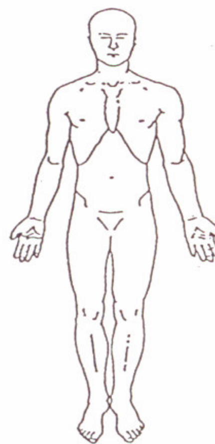
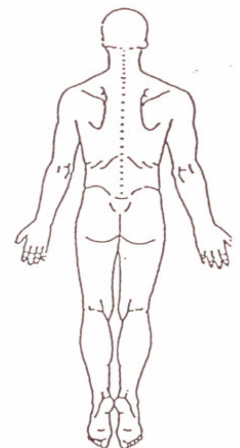
Please explain any YES answers.____

In the diagram on the right, please mark the area(s) where your pain/symptom(s) are located using the following symbols: X = Pain, /// = Pins & Needles, O = numbness, ^^^ =Shooting Pain

Please rate your pain right now on a scale of 0 – 10 With 0 being no pain and 10 being the worst pain Imaginable:

0---1---2---3---4---5---6---7---8---9---10

What do you rate your pain at it's lowest ?___/10
What do you rate your pain at it's highest?___/10

Signature:____Date__________________