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Function First Physical Therapy, P.C.

Patient Intake Form

Patient Information:

Last Name: ________________________________ *First Name:* ___________________________
Sex: _________
Date of Birth: _________

Address: _____________________________________ *City:* ______________________________
State: ______ *Zip Code:* _______________ *Work#: (   )* _________-_________
*Home#: (   )*_________-_________
Mobile#: (   ) __________-_________
Emergency Contact: ____________________________________
Phone#: (   ) ___________-____________

Email: ____

*Marital Status: Single*______ *Married* ______ *Divorced* ______ *Widowed* _______ *Domestic Partner* _______

Employer's Name: __________________________________
Occupation: ________________________________

Physician's Name: ___________________________________
Diagnosis: ________________________________

Injury: Work or Auto related? _________
Allergies or Medical Precautions: ___________________________

Follain Physical Therapy,

<u>Patient Questionnaire/ History</u>

Name: ____Date of Birth: ____________

_____Right or _____Left-handed.

What is your Chief Complaint?

____

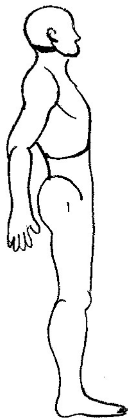
____

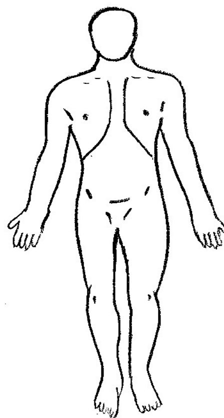
____

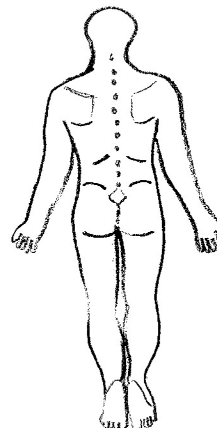
Rate your chief complaint in order of severity from worst (5) to least (1)

Pain____ Decreased Motion____ Swelling/edema____ Stiffness____ Loss of function_________________ Where is your problem? Indicate on the body chart. Pain xxx: Numbness ooo: Tingling zzz:

Indicate the nature of your pain and symptoms: ___Sharp ___Dull ___Piercing ___Shooting ___Aching ___Deep ___Superficial ___Tingling ___Numbness ___Intermittent ___Burning ___Stabbing







When and how did this problem begin?

____

____

What makes your symptoms/ pain worse?
____

____

What makes your symptoms/ pain lessen?
____

____

Are your symptoms worse in the: _____Morning _____Afternoon _____Evening _____ Inconsistent_____

Are your symptoms: ____________Improving ____________Worse _________

Stable________________

Follain Physical Therapy
Medical History

Has this problem affected your daily life or routine? Briefly describe in what ways.
____

____

*Have you undergone any special tests for this condition? (X-rays, MRI's, ETC) If yes, do you know the results?*____

____

Please answer the following questions: Y N

Question	Y	N
1) Do the current problems interrupt your sleep?		
2) Do your symptoms change with coughing or sneezing?		
3) Have you had any recent changes in bowel or bladder function?		
4) Do you experience any dizziness or vertigo?		
5) Have you had any recent change in your weight or appetite?		
6) Do you have any intolerance to hot or cold?		
7) Do you have any bruising or bleeding disorders?		
8) Have you had any skin changes, such as rashes or discoloration?		
9) Have you experienced any changes in your vision, such as blurring, double vision, or decrease in your visual fields?		
10) Have you had a recent episode of nausea/vomiting?		
11) Are you pregnant?		

12) Do you have osteoporosis? Date of your last bone scan:		
13) Do you have any allergies?		
14) Have you noticed any shortness of breath or decrease in exercise tolerance?		
15) Do you use any assistive device? (Cane, Brace)		
16) Do you have high blood pressure?		
17) Do you have any cardiac problems?		
18) Do you have diabetes?		
19) Have you ever had cancer of any sort?		
20) Do you have a history of neck or back problems?		

Any other illness, past injuries I should be aware of?

____

Past surgeries: ___yes, ___no, give brief details:

____

List the medications you are currently taking (over the counter/prescription):

____

____

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Social History

Are you presently working? ______Yes, ______No

Physical/Emotional demands of present occupation? (High, moderate, minimal)

____

Overall activity level: _____Sedentary, _____Light, _____Moderate, _____Heavy, _____Very heavy.

Sports and Exercise (Type, Frequency, Duration)

____

____

Use of Tobacco ____Yes, ____no. Use of Alcohol ____Yes, ____No.

Family medical History:

Does anyone in your immediate family (mother, father, siblings) have a history of Diabetes,
High Blood Pressure, Cardiac Problems, or Cancer?

____

____

Please list 3 goals of Physical Therapy and time frames:

1) ____
2) ____
3) ____

Who can we thank for this referral?

____

Signature: ____

*Parent or Guardian Signature:*____

Date: __________________

Thank You for Considering Follain Physical Therapy