Patient Intake Questionnaire

S.P.O.R.T. PHYSICAL THERAPY CLINIC

Patient Name: _____ **Date:** _____

What is the reason for your visit today? _____

Date of injury / onset of symptoms? _____

Since onset, are your symptoms (circle one): Improving Worsening Not Changing

Frequency of symptoms (circle one): Constant Intermittent/Daily Occasional

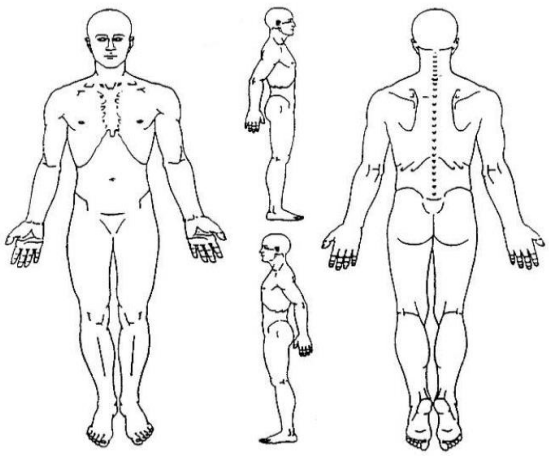
Date of surgery (if applicable): _____

MEDICAL HISTORY

Do you currently have or do you have a past history of any of the following:

	Yes	No	If yes, please explain:
Cancer			
Diabetes			
High Blood Pressure			
Heart Disease			
Angina (Chest Pain)			
Pacemaker			
Stroke			
Osteoporosis			
Osteoarthritis			
Rheumatoid Arthritis			
Headaches			
Kidney Disease			
Seizures			
Urinary Incontinence			
Other			

Please indicate below where your symptoms are located:



Key: Use symbol(s) below to mark area(s) of discomfort

Numbness: ==========

Pins/Needles: 0000000000

Stabbing Pain: ////////////////

Burning Pain: XXXXXXXX

Past Surgical History

Spine	Y / N	Date: _____
Shoulder	Y / N	Date: _____
Knee	Y / N	Date: _____
Hip	Y / N	Date: _____
Ankle	Y / N	Date: _____
Hand	Y / N	Date: _____

Other Surgeries:

_____

_____

_____

_____

Are you currently pregnant? Y / N

Current Pain Rating (circle all that apply):

Burning	Throbbing
Sharp	Shooting
Dull	Stabbing
Tight	Tingling
Numb	Other _____

OVER . . . . . .

Have you had any of the following diagnostic, medical, or rehabilitative services for your current symptom(s)/injury? (circle all that apply)

Chiropractic/Osteopath	Massage Therapy	Occupational Therapy	Physical Therapy
Neurologist	Orthopedist	Injection	EMG/NCV
CT Scan	MRI	X-rays	Other _____

MEDICATIONS: Please list all medications you are taking, including dosage, frequency, and route of administration. Include all prescriptions, over-the-counter, herbal/vitamin/mineral supplements. Please complete to the best of your ability. If you have a list of your current medications, please provide a copy to the receptionist.

_____ List attached **_____ I am not taking any medications, vitamins, or supplements**

Medication Name	Dosage	Frequency	Route of Administration (oral, cream, etc.)
		1 2 3 4 x/day PRN	
		1 2 3 4 x/day PRN	
		1 2 3 4 x/day PRN	
		1 2 3 4 x/day PRN	
		1 2 3 4 x/day PRN	
		1 2 3 4 x/day PRN	

Do you have any allergies? Y / N

If yes, please explain: _____

I certify to the best of my knowledge that the above information is complete and accurate.

_____ _____

Patient/Parent/Guardian Signature **Date**