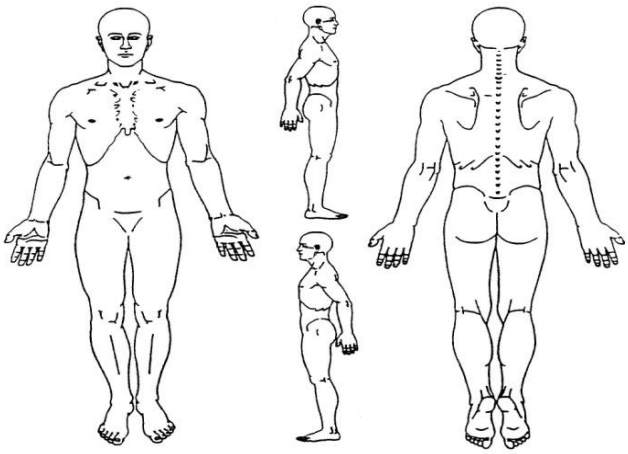
Physical Therapy Solutions
Solutions for an ACTIVE life

PHYSICAL THERAPY SOLUTIONS

Intake Questionnaire

Name: _____
Date: _____
Injured side: Left Right Both
Referring Physician: _____
Family Physician: _____
Date symptoms started:_____
How did the injury occur: _____
_____
_____

*Please circle where you are experiencing symptoms.



RATE YOUR PAIN: (Please circle appropriate # on scale)

AT BEST	**No Pain**	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Unbearable**
AT WORST	**No Pain**	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Unbearable**

Health History:

Mark one box for each item:	**No**	**Yes**	**Explain:**
Bleeding Disorder/Blood Clots	☐	☐	
Diabetes	☐	☐	
Fibromyalgia	☐	☐	
Heart Condition	☐	☐	
High Blood Pressure	☐	☐	
Arthritis	☐	☐	
Asthma	☐	☐	
Allergies	☐	☐	
Cancer	☐	☐	
Surgical History	☐	☐	
Smoker/tobacco	☐	☐	
Pacemaker	☐	☐	
Allergic to latex	☐	☐	
Pregnant	☐	☐	
Osteoporosis	☐	☐	
Have you fallen in the past year?	☐	☐	
Do you have bowel or bladder problems?	☐	☐	
Do you have dizziness/vertigo?	☐	☐	

Mental Health: ☐ Anxiety ☐ Depression ☐ Other: _____

MEDICATIONS: (For this current problem.)

_____

****Other medications you take often play a role in your physical therapy treatment. Please list all of your current medications or provide a list to our front office staff and they will make a copy to place in your chart for your therapist to review.*

Previous treatments for current pain:

Chiropractic care ☐
Orthotics ☐
Splints/braces ☐
Injections ☐
Surgery ☐
Physical Therapy ☐
Other, please explain:_____

Circle all activities that you have difficulty with:

Walking	Squatting
Sitting	Reaching Overhead
Standing	Reaching behind Back
Sleeping	Pushing/Pulling
Lifting	Going up/down Stairs
Carrying	Getting in/out of a Chair
Working	Driving

Other, please explain_____