WALKER PHYSICAL THERAPY & SPORTS INJURY CENTER

MEDICAL INTAKE FORM

Thank you for choosing Walker Physical Therapy and Sport Injury Center.
Please take your time while answering the following questions as it will help us give you the best care possible.

PATIENT HISTORY

Patient Name: _____ Age:_____ Diagnosis:_____

Referring Physician:_____ Recent Surgery and Dates:_____

Medications: 1. _____ Dosage: _____ Frequency: _____

2. _____ Dosage: _____ Frequency: _____

3. _____ Dosage: _____ Frequency: _____

4. _____ Dosage: _____ Frequency: _____

Other Medications/Vitamins: _____

CURRENT CONDITION

Date of injury: _____ Mechanism of injury: _____

Describe your chief complaint / concern: _____

_____

Identify any position / activity that eases your symptoms: _____

_____

Identify any position / activity that aggravates your symptoms: _____

_____

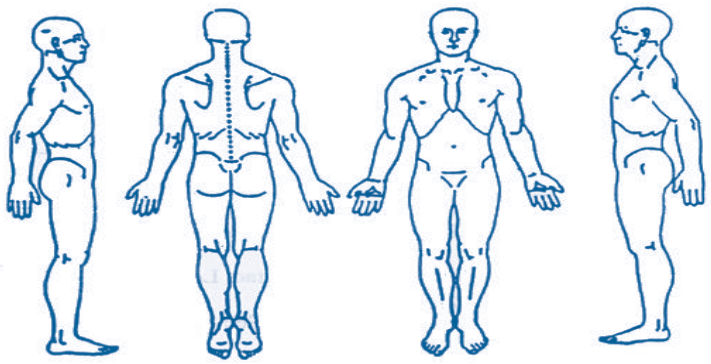
What is your goal with physical therapy: _____

_____

BODY CHART / PAIN LEVEL

Mark areas where you feel symptoms. Use the symbols to describe your symptoms and rate the pain 0-10 with 0 as no pain and 10 as so intense you would need to go to the emergency room.

T = Tingling
N = Numbness
P = Pain
S = Shooting / Sharp pain



Do your symptoms (check one:)
o Come and go o Constant o Change with activity

Does your pain / symptoms subside while resting at night? o Yes o No

CURRENT SYMPTOMS / CONDITION

(check all that apply)

o Cancer / infection o Fever, chills, night sweats o Nausea / vomiting o Unexplained weakness / pain	o Recent falls o Balance / dizziness o Weakness / joint pain o Numbness / tingling	o Abdominal pain / pulsating o Blood in urine o Changes in bowel / bladder o Difficulty swallowing
o Pregnancy o Smoker o Confusion / memory loss o Pacemaker	o Shortness of breath o Excessive cough o Severe pain in calf o High blood pressure	o Diabetes o Excessive thirst o Insulin dependent Injection time _____

During the past month, have you been feeling down, depressed, or hopeless? o Yes o No

During the past month, have you been bothered by having little interest or pleasure in doing things? o Yes o No

If yes to either question above, is this something you would like help with? o Yes o No

PAST MEDICAL HISTORY

List any medical condition you have been diagnosed with or hospitalized for:

_____

_____

_____

_____

_____

Patient / guardian signature: _____ Date: _____

Physical Therapist Use Only

(notes for follow-up questions)

_____

_____

_____

_____

_____

_____

_____

_____

BP _____ Falls efficacy scale _____ Tug _____ SLS (R) _____ (L) _____