alliant
physical therapy &
integral medicine

Optimizing *'What Works Best'* within each Individual Person

Physical Therapy Intake Form (Please fill out completely)

Name_____ **Date**_____

DOB _____ **Age** _____ **Ht** _____ **Wt**_____

Current complaints/what brought you to Physical Therapy?

1._____**How Long?**_____

2._____**How Long?**_____

3._____**How Long?**_____

Have you been treated for this problem (PT, Chiropractic, Massage, Injections?) _____**How Long Ago?** _____

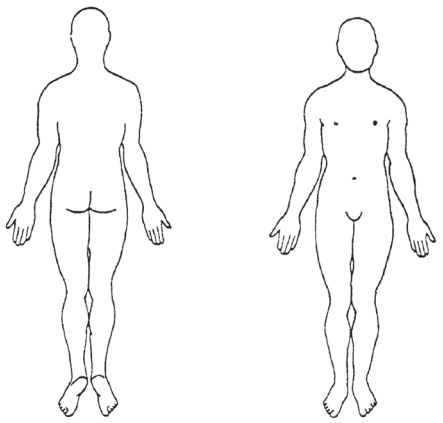
Have you received any special tests for this problem (X-Ray, MRI, Blood, etc.?) _____

My symptoms are currently ❒ Getting Better ❒ Getting worse ❒ Staying the same

I should not do physical activity that might make my pain worse ❒ Agree ❒ Unsure ❒ Disagree

Do you expect to return to the activity levels you were at prior to developing these symptoms ❒ Yes ❒ No

Please mark the location of your pain



List 3 postures or activities that make your symptoms worse

1._____

2._____

3._____

List 3 postures or activities that make your symptoms better

1._____

2._____

3._____

My symptoms ❒ Come and go ❒ Are constant ❒ Are constant but change with activity

How are you able to sleep at night due to your symptoms?

❒ No problem sleeping ❒ Difficulty falling asleep ❒ Awakened by pain ❒ Sleep only with medication

When are your symptoms the worst? ❒ Morning ❒ Afternoon ❒ Evening ❒ Night ❒ After exercise

When are your symptoms the best? ❒ Morning ❒ Afternoon ❒ Evening ❒ Night ❒ After exercise

Using the 0 to 10 scale, with 0 being "no pain" and 10 being the "worst pain imaginable" please describe:

Your current level of pain while completing this survery: 0 1 2 3 4 5 6 7 8 9 10

The best your pain has been during the past 24 hours: 0 1 2 3 4 5 6 7 8 9 10

The worst your pain has been during the past 24 hours: 0 1 2 3 4 5 6 7 8 9 10

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Medical Screening Information.

Please fill out completely so we can better understand your overall health and possible contributing factors to your problem.

Occupation, including activities that make up your work day. (sitting, driving, how long, etc.)_____

Leisure activities including exercise routines _____

Are you on any work restrictions from your doctor? _____

Do you use tobacco? (smoke/chew) ❒ Yes ❒ No

Have you ever had cancer? ❒ Yes ❒ No **Body Part/Type**_____ **When**_____

Have you ever taken steroid medications for any medical condition? ❒ Yes ❒ No _____

Have you (circle one) **ever taken or are currently taking a blood thinner or anti-coagulant medication?** ❒ Yes ❒ No

Do you have a pacemaker, transplanted organ, joint replacement, breast implants or any other implants? ❒ Yes ❒ No

If yes, please explain _____

Do you have diabetes? ❒ Yes ❒ No

Have you had a cold or other recent infection in the last 6 weeks? ❒ Yes ❒ No_____

Previous surgeries or injuries. Include date.

_____ _____

_____ _____

_____ _____

Current Medications (Include pills, skin patches, injections and non-prescription/over the counter drugs, and supplements)

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

Are you allergic to any medications? _____

Have you recently noted any of the following (check all that apply)?

❒ fatigue
❒ fever/chills/sweats
❒ nausea/vomiting
❒ weight loss/gain
❒ difficulty maintaining balance while walking
❒ falls
❒ numbness or tingling
❒ muscle weakness
❒ dizziness/lightheadedness
❒ heartburn/indigestion
❒ difficulty swallowing
❒ changes in bowel or bladder function
❒ constipation
❒ diarrhea
❒ shortness of breath
❒ fainting
❒ cough
❒ headaches

Have you ever been diagnosed with any of the following conditions (check all that apply)?

❒ cancer
❒ heart problems/disease
❒ chest pain/angina
❒ high blood pressure
❒ circulation problems
❒ blood clots
❒ stroke
❒ anemia
❒ bone or joint infection
❒ chemical dependency (i.e., alcoholism)
❒ depression and/or anxiety
❒ lung problems/respiratory disease
❒ tuberculosis
❒ asthma
❒ rheumatoid arthritis
❒ other arthritic condition
❒ bladder/urinary tract infection
❒ kidney problem/infection
❒ sexually transmitted disease/HIV
❒ pelvic inflammatory disease
❒ thyroid problems
❒ diabetes
❒ osteoporosis/osteopenia
❒ multiple sclerosis
❒ epilepsy / seizures
❒ eye problem/infection
❒ ulcers
❒ liver problems
❒ hepatitis
❒ pneumonia

Has anyone in your immediate family (parents, brothers, sisters) ever been diagnosed with any of the following conditions (check all that apply)?

❒ cancer
❒ heart problems
❒ high blood pressure
❒ diabetes
❒ stroke
❒ depression
❒ tuberculosis
❒ thyroid problems
❒ blood clots

What is your "best case scenario" from participating in therapy? _____