



Office Use Only
Patient # _____

New Patient Intake Form

Date: _____

Patient Name: _____ DOB _____ Occupation: _____

Referring MD: _____ Diagnosis: _____

Primary Care Physician: _____ Phone: _____

Date of First MD visit for this injury: _____ Next MD appointment: _____

Reason for today's visit: _____

When did you first notice symptoms of your problem? _____

Did your symptoms arise gradually? YES or NO Was there a sudden onset? YES or NO

Was there any trauma/accident that may have caused your complaints/problem? YES or NO

Please elaborate: _____

What are your present symptoms? _____

How do your present symptoms compare to your original complaint(s)? _____

Rate your pain on a scale of 0 (No Pain) to 10 (Excruciating pain that is disabling and requires emergency care.)

At the best moment in the past 48 hrs. _____ During the night _____ At the worst moment in the past 48 hrs. _____

Is your pain (please circle) CONSTANT or INTERMITTENT? Does your pain wake you at night? YES or NO

Does your pain fluctuate depending on your activities? YES or NO

Does your pain follow a pattern where it is worse in the AM or PM (circle one if yes) YES or NO

Does your pain radiate from one area to other areas? YES or NO

What activities increase your pain? _____

What activities decrease your pain? _____

Do you normally participate in any fitness activities or recreational sports? YES or NO

Please list: _____

How have you modified your activities? _____

Did your referring MD give you any instructions (i.e. for exercise, weight bearing, weaning from crutches, use of a brace?)

YES or NO Please elaborate: _____

Have you missed any work due to this injury? YES or NO

If so, what was your last day of work? _____ Date returned to work: _____ Worked part-time for period of: _____

Have you had any diagnostic tests performed? YES or NO If so, please indicate which test(s) and approximate date(s)

X-Ray: _____ MRI: _____ CT SCAN: _____ Bone Density: _____

EMG: _____ NCV: _____ OTHER(s): _____

Have you had surgery for this injury? YES or NO If so, how many have you had? 1 2 3 4

Procedure(s) performed _____

Most recent surgery performed? _____ Surgeon: _____ Date: _____

Are you currently taking any medications (for this condition or anything else? YES or NO

Please list the appropriate categories:

Anti-inflammatory(s): _____ High Blood Pressure Med(s): _____

Muscle Relaxants: _____ Bone Density Drugs: _____

Pain Medications: _____ Beta Blockers: _____

Antibiotics: _____ Other(s): _____



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Have you sought care from any of the following medical providers for this injury/episode? YES or NO

Acupuncturist _____	Massage Therapist _____	Physical Therapist _____
Chiropractor _____	Neurologist _____	Podiatrist _____
Emergency Room _____	Occupational Therapist _____	Other(s) _____
General Practitioner _____	Orthopedist _____	_____

Medical History: Please check if you have had problems with the following:

_____ Anemia	_____ Cancer	_____ Glaucoma	_____ Kidney	_____ Skin
_____ Arthritis	_____ Diabetes	_____ Gynecologic	_____ Liver Disease	_____ Speech
_____ Back Trouble	_____ Drug or alcohol abuse	_____ Hearing	_____ Lung	_____ Stomach Ulcers
_____ Bleeding disorder	_____ Ear, Nose, Throat, Mouth	_____ Heart	_____ Mental Health	_____ Stroke
_____ Blood Clots	_____ Falls/Balance Problems	_____ High Blood Pressure	_____ Pancreatitis	_____ Swallowing
_____ Blood Transfusion	_____ Fracture	_____ HIV/AIDS	_____ Prostate	_____ Thyroid
_____ Breast Cancer	_____ Gallstones	_____ Intestinal	_____ Seizures	_____ Other - specify

This intake form was reviewed by: _____
(Therapist Signature)

Date: _____