

# Great Basin Physical Therapy and Performance Center

## Patient Intake Form

### Patient

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

DOB: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Age: \_\_\_\_\_ DATE: \_\_\_\_\_

Occupation: \_\_\_\_\_

Date of Injury: \_\_\_\_\_ Date of Surgery: \_\_\_\_\_

Are you receiving Home Health Care?  Yes  No Are you currently pregnant?  Yes  No

What caused your current problem? \_\_\_\_\_  
\_\_\_\_\_

Have had this problem before?  Yes  No If Yes when and where? \_\_\_\_\_  
\_\_\_\_\_

Have your symptoms gotten worse?  Yes  No

What makes your symptoms better? \_\_\_\_\_

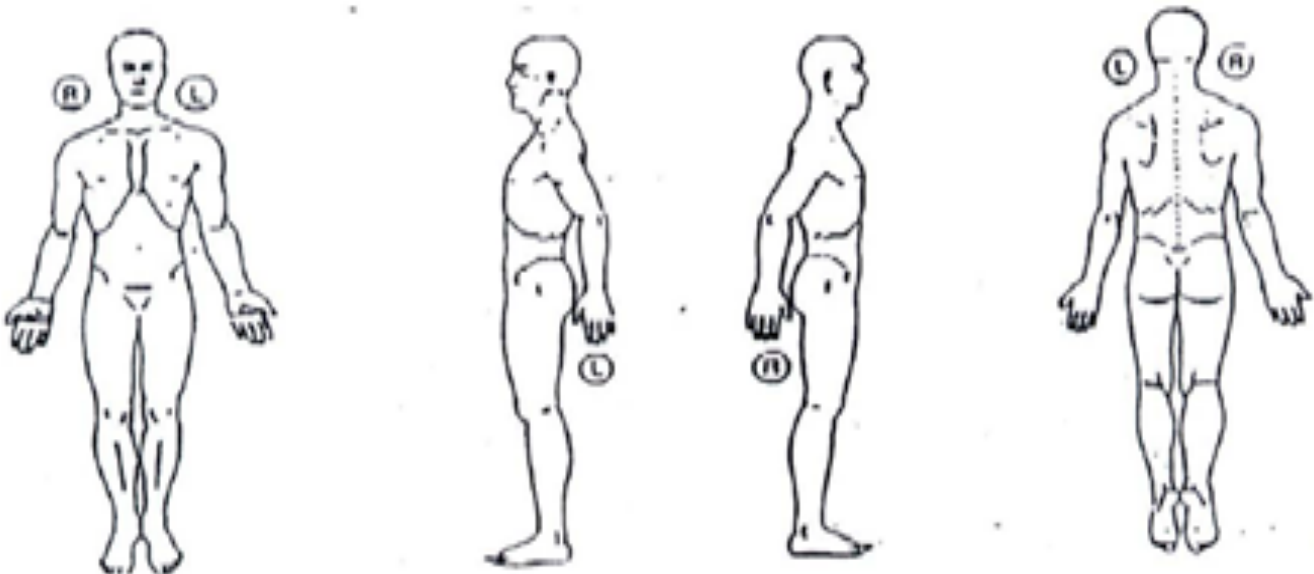
What makes your symptoms worse? \_\_\_\_\_

Are you able to sleep with this problem?  Yes  No  Sometimes

Is your pain worse in the:  Morning  Midday  Evening  All day

List **all** medications you are currently taking: \_\_\_\_\_  
\_\_\_\_\_

Your pain: Draw the areas of pain (////) ; tingling (XXXX) ; numbness (>>>>)



# Great Basin Physical Therapy and Performance Center

## Patient Intake Form

Tests Performed (check all that apply)

- X-Ray                       MRI                       Epidural                       Cortisone
- Other: \_\_\_\_\_

Past Medical History (Major illness and surgeries): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you now or in the past have you had problems with (check all that apply):

- Allergies                       Osteoarthritis                       Rheumatoid Arthritis                       Cancer:
- Joint pain                       Diabetes                       Head Injury                       Heart problems
- Stroke                       Heart Attack                       Seizures                       Blood Pressure
- Head Aches                       Thyroid                       MS                       Asthma
- Osteoporosis                       Balance Issues                       Pacemaker                       Parkinson's
- Defibrillator                       Other: \_\_\_\_\_

What are your Physical Therapy Goals?

- Decrease pain                       Increase strength                       Increase endurance
- Increase range of motion                       Return to work                       Return to prior level of function
- Return to sport activities: \_\_\_\_\_
- Other Pertinent Information: \_\_\_\_\_
- \_\_\_\_\_

Patients Initials: \_\_\_\_\_

Therapist Initials: \_\_\_\_\_