Great Basin Physical Therapy and Performance Center

Patient Intake Form

Patient Name:______________________DOB:_______Age:_____Height:_______ Date:________

Occupation:____________________Date of Injury:_______ Date of Surgery:________ Weight:_________

Are you receiving Home Health Care? _________

Who were you referred by?____

Are you pregnant? O Yes O No If yes, How many months along? _________

Do you have a pacemaker or other implanted device? O Yes O No If yes, what type?_____________

What caused your current problem?____________________________________

Have had this problem before? O Yes O No If Yes when and where?_________________

Have your symptoms gotten worse? O Yes O No

What makes your symptoms better?____________________________________

What makes your symptoms worse?____________________________________

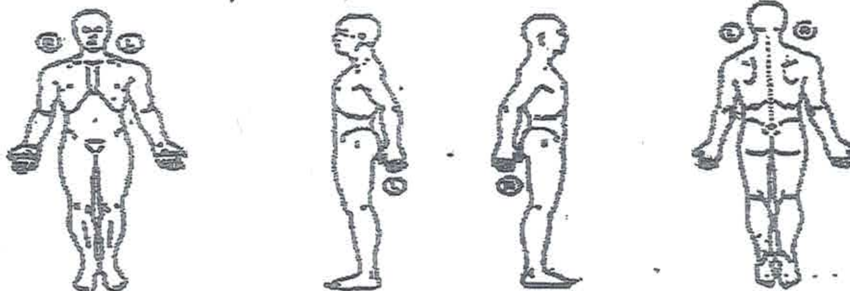
Are you able to sleep with this problem? O Yes O No O Sometimes

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

List all medications you are currently taking:______________________________

____

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



Tests Performed (check all that apply): O X-Ray O MRI O CT Scan

Injections: O Trigger Point O Cortisone O Epidural O Other:_________________

Past Medical History (Major illness and surgeries):___________________________

____

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

O Allergies	O Arthritis	O Asthma	O Cancer:
O Joint pain	O Diabetes	O Head Injury	O Heart problems
O Stroke	O Heart Attack	O Seizures	O Blood Pressure (High or Low)
O Head Aches	O Thyroid	O MS	O Parkinson's
O Osteoporosis	O Balance Issues	O Pacemaker	O Defibrillator

What are your Physical Therapy Goals?

O Decrease pain O Increase strength O Increase endurance O Increase range of motion

O Return to work O Return to prior level of function O Return to sport activities ( )

O Other Pertinent information:____

Patients Initials:_________ Therapist Initials: _________