

Healing Pathway Physical Therapy Patient Intake Form

Patient Full Name: _____ Date: _____
 Date of Birth: _____ Age: _____ Home phone#: _____ Cell#: _____
 Address: _____ City/State: _____ Zip _____
 Occupation: _____ Employer: _____ Work #: _____
 Describe your work activities: _____
 Work Address: _____ Email: _____
 Referring Physician: _____ Primary Care Provider: _____
 Emergency contact: _____ Relation: _____ Phone #: _____
 How did you hear about Healing Pathway PT? _____

Please list any medications/ supplements/ remedies _____

Are you Right/ Left handed? _____ Any allergies (including latex): _____

What position(s) do you sleep in? Back _____ Stomach _____ R side _____ L side _____ All _____
 Please list any previous surgeries and year? _____

How would you describe your general health? _____
 Stress level? _____
 Weekly exercise / recreational activity? _____

Have you ever had/ been diagnosed with the following conditions: please circle and describe:

Neurological issue	Headaches	Infectious Disease	Arthritis
Heart Attack	Asthma	Gout	Osteoporosis
Diabetes type I / II	Emphysema	Current tobacco use	Weakness
Heart condition	Shortness of breath	Hernia	Dizziness/ Fainting
High / Low blood pressure	Vision / Hearing issues	Pins / implants / Pacemaker	Bowel/ Bladder issues
Sleeping Problems	Stroke/ TIA	Anemia	Weight/Energy loss
Epilepsy / seizure	Blood clot/ Emboli	Allergies	Emotional issues
Cancer	Chemo/ Radiation	Multiple Sclerosis	Current Pregnancy
Stomach/ GI issues	Lung condition	HIV/Aids	Parkinson's

List any significant family history: _____

Any additional comments/ concerns: _____

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Please describe what brings you here for treatment: _____

Date of Injury/ Symptom onset: _____ How many hrs/wk are you working: _____

How did symptoms begin? _____

Since your problem began, is it getting better _____, staying the same _____, getting worse _____?

Average pain level _____ / 10 Lowest pain level _____ /10 Worst pain level _____ /10

What makes your symptoms better? _____

What makes your symptoms worse? _____

Is there anything you can't do because of pain / dysfunction? _____

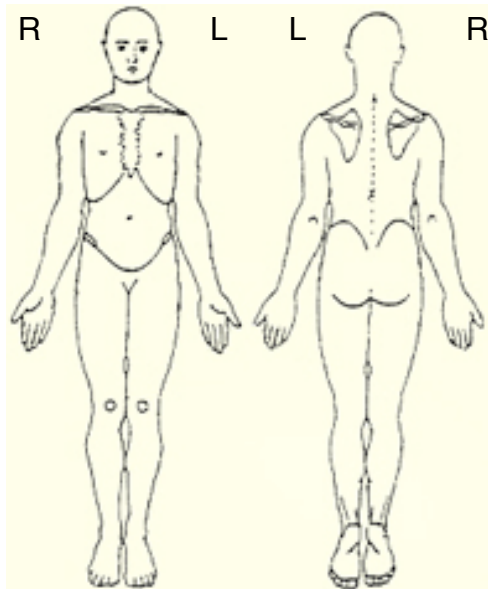
Do you awake at night from pain/ how many times? _____ Avg hours/night: _____

When are your symptoms worst? Rising from bed _____ am _____ pm _____ activity dependent _____

What treatments have you sought for this condition? None _____ Medication _____ PT _____

Chiropractic _____ Massage _____ Acupuncture _____ Counseling _____ Injections _____

Bracing _____ Surgery (type/date) _____ Other _____



Please mark your symptoms on the diagram and describe:

key: pain **xxx** pins/needles... shooting >>> constant **C**
numbness **ooo** primary area(s)***

Have you had any imaging/ tests related to this issue? Xray/CT _____ MRI _____ Bone Scan _____
EMG/NCV _____ If so, list date/facility where performed and results: _____

Since onset of your symptoms, have you had: numbness in face and/or genital area _____
malaise _____ weakness _____ fever/chills _____ night pain _____ unexplained weight change _____
difficulty w/ control of bowel or bladder function _____ dizziness/fainting _____ numbness _____

Are you aware of your diagnosis/ prognosis as explained to you by your primary care provider?

Yes _____ No _____

What are your rehabilitation goals and expectations from this program? _____
