thrive again PHYSICAL THERAPY
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INTAKE FORM

Today's Date _____

PATIENT INFORMATION

Full Name _____ Date of Birth _____

Phone Mobile# _____ Home # _____ Work # _____

Email _____ Gender _____ Legal Gender (if different) _____

Address Street _____

City _____ State _____ Zip Code _____

EMERGENCY CONTACT

Full Name _____ Relationship _____

Phone # _____

REFERRAL INFORMATION

How did you hear about Thrive Again PT? _____

Referral Name _____ Relationship _____

MEDICAL RECORDS

If a copy of your visit needs to be sent to a healthcare provider, please provide the following:

Name: _____ Fax #: _____

HEALTH INFORMATION

Age: _____ Height: _____ Weight: _____

List your Leisure Activities (including exercise reoutines): _____

Occupation (including activities that compromise your work day _____

_____

Are you on a work restriction from your doctor? YES NO

Are you latex sensitive? YES NO

Do you smoke? YES NO Do you have a pacemaker? YES NO

Are you currently pregnant or think you might be pregnant? YES NO

Do you have an IUD? YES NO

Please provide your pregnancies/birth history _____

Date of last period: _____ Date of last pelvic exam: _____

Please list any surgeries or other conditions for which you have been hospitalized (include dates):

1 _____ 2 _____

3 _____ 4 _____

Please list any other accidents, injuries or major illness (including motor vehicle and dates):

_____

_____

SYMPTONS

Check all that apply

Fatigue	Changes in bowel or bladder functions
Fever / Chills / Sweat	Incontinence
Nausea / Vomiting	Pain with Menstrual Period
Difficult Balance When Walking	Prolapse
Falls	Abdominal Pain / Bloating / Gas
Changes in Urine Color/Smell/Blood in Urine	Constipation
Pelvic Pain	Diarrhea
Endometriosis	Shortness of Breath
Gastrointestinal Issues (IBS, Crohn's)	Fainting
Chemical Dependency	Cough
Numbness or Tingling	Headaches
Muscle Weakness	Pain with Intercourse
Dizziness / Light Headedness	Fibroids
Hearburn / Indigestion	Cysts
Difficulty Swallowing	

What date (roughly) did your present symptoms start? (m/d/y) _____

What do you think caused your symptoms? _____

My symptoms are currently: BETTER WORST SAME

My symptoms are currently: COME & GO CONSTANT

I should not do physical activities that might make my pain worse:

DISAGREE AGREE UNSURE

Have you ever had this problem before? YES NO When? _____

Have you received treatment for this problem? YES NO (if yes, please list below)

Treatment received so far for this problem (e.g. chiropractic, injections) _____

Please list special tests performed for this problem (e.g. x-ray, MRI, Labs) _____

How long did it take for you to feel better? _____

Circle the number that best represents your average pain. (0 = no pain and 10 = worst pain imaginable)

What is the LEAST?	0	1	2	3	4	5	6	7	8	9	10
What is the WORST?	0	1	2	3	4	5	6	7	8	9	10
What is it TODAY?	0	1	2	3	4	5	6	7	8	9	10

What is the quality of your pain?

Sharp	Stabbing	Radiating
Dull	Throbbing	Tearing
Achy	Deep	Gripping
Burning	Shooting	Ripping

Other: _____

Aggravating Factors: Identify up to 3 important positions or activities that make your symptoms worse:

1 _____
2 _____
3 _____

Easing Factors: Identify up to 3 important positions or activities that make your symptoms better:

1 _____
2 _____
3 _____

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

No Problem Sleeping	Awakened by Pain
Difficulty Falling Asleep	Sleep Only with Medication

When are your symptoms worst?

Morning	Evening	After Exercise
Afternoon	Night	

When are your symptoms best?

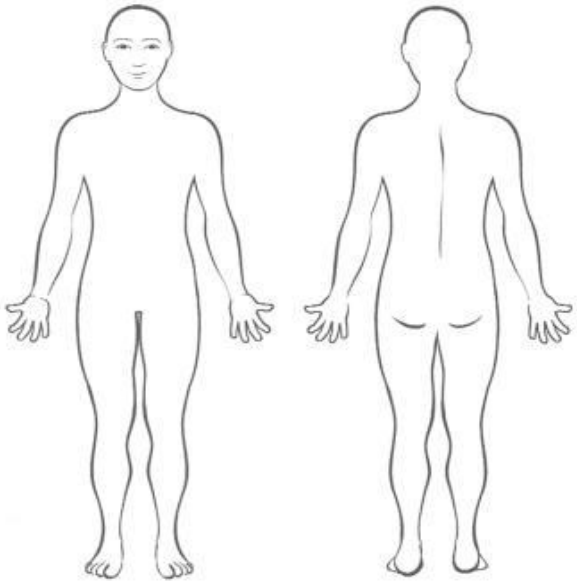
Morning	Evening	After Exercise
Afternoon	Night	

Does taking a deep breath aggravate your symptoms?	YES	NO
Does twisting your back aggravate your symptoms?	YES	NO
Has there been any change in bowel habit since onset of your symptoms?	YES	NO
Does eating foods aggravate your symptoms?	YES	NO
Has there been a weight change since onset of symptoms?	YES	NO

BODY CHART

Mark the body chart using the symbols below to describe the symptoms you are feeling.

Symbols	Symptoms
-	Shooting / Sharp Pain
O	Dull / Aching Pain
III	Numbness
=	Tingling



DIAGNOSED CONDITIONS

Have you ever been diagnosed with any of the following listed below?

Cancer
Heart Problems
Chest Pain / Angina
High Blood Pressure
Circulation Problems
Blood Clots
Stroke
Anemia
Bone or Joint Infections
Chemical Dependency (e.g. Alcoholism)
Depression
Lung Problems
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
Multiple Sclerosis
Epilepsy
Concussion / Head Injury
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
Blood Clots
Tuberculosis
Thyroid Problems
Depression

DURING THE PAST MONTH

Have you been feeling down, depressed or hopeless?	YES	NO
Have you been bothered by having little interest or pleasure in doing things?	YES	NO
Is this something with which you would like help?	YES	NO
Do you ever feel unsafe at home or has anyone hit you or tried to injure you?	YES	NO

MEDICATIONS

Please list any medications you are currently taking (including pills, injections and/or skin patches):

1 _____ 2 _____
3 _____ 4 _____
5 _____ 6 _____

Have you ever taken any of the following medication(s) for any medical conditions?

Steroids Blood Thinning Anticoagulant

List all medications you are allergic to: _____

_____

AGREEMENT

I certify that the above information is correct to the best of my knowledge. I have disclosed all medical conditions that I am aware of and will inform my practitioner of any changes in my health status. I understand that these services are a health aid and not a substitute for a doctor's care.

Patient Signature: _____ Date: _____