



Fitness Center

Physical Therapy Clinic
and Health Club

INTAKE INTERVIEW

Name: _____ Today's Date: _____

Age: _____ Occupation: _____ Weight: _____ Height: _____

Diagnosis: _____

Surgeries (include dates): _____

Presently working: Yes No (date last worked): _____

Referring Physician: _____ Next Drs Apt: _____

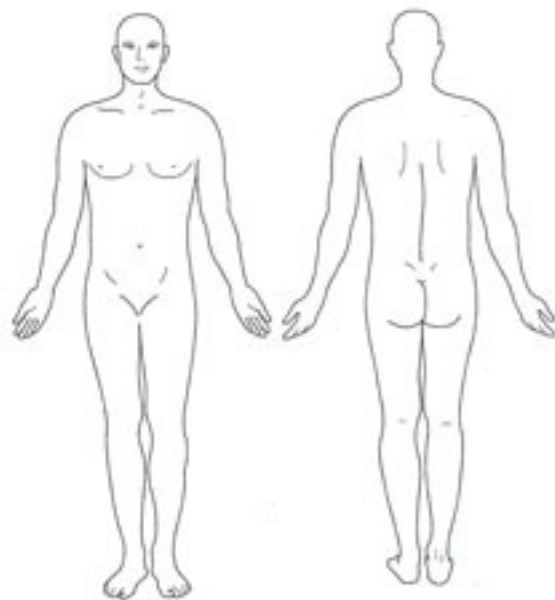
1. When did your symptoms begin: _____

2. How did your symptoms start/what happened: Gradual Onset Sudden Onset Injury
 Unknown Other: _____

3. Describe your symptoms:

- Sharp/Stabbing: _____
- Burning: _____
- Pins & needles: _____
- Tingling: _____
- Dull ache: _____
- Cramping: _____
- Electrical: _____
- Constant: _____
- Intermittent: _____
- Other: _____
- Other: _____

4. Where does it hurt? On the body diagram, mark the location of your symptoms.



Please continue on the opposite side.

5. How much does it hurt on a scale of 0 (no symptoms) to 10 (worst possible symptoms - call an ambulance) at rest _____ and with activity _____?
6. Since the onset of your symptoms, have they worsened lessened stabilized?
7. What makes your symptoms worse? sitting walking lifting morning evening
 other: _____
8. What makes your symptoms better? rest ice heat changing positions
 other: _____
9. Have you had these symptoms in the past? No Yes (when): _____
10. How were your symptoms treated at that time: _____
11. Are you taking any medications for your symptoms: No Yes: _____
12. Other medications: _____

13. Medical Conditions/Allergies

- | | | |
|---|---|---|
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Emotional stress |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Bowel/Bladder problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Recent weight change | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> HIV + | <input type="checkbox"/> Other: _____ |

Allergies: _____

14. Do you have any open wounds? No Yes (where): _____
15. Do you have any metal in your body? No Yes (where): _____
16. Are you pregnant? No Yes (due date): _____
17. Diagnostic tests: X-ray MRI CT Scan EMG Myelogram Other
18. Describe your personal goals/reasons for coming to Physical Therapy: _____

Patient consent for Physical Therapy

 Patient Signature (Parent or Guardian if minor)

Date: _____

 Physical Therapist

Date: _____

I have reviewed this form with the patient during the initial evaluation.