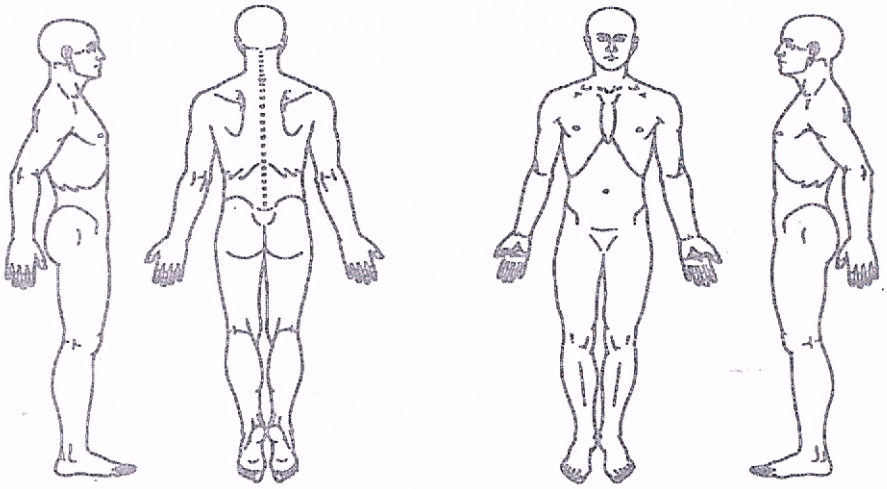
Advanced Motion
PHYSICAL THERAPY

Physical Therapy Intake Form

Where is your pain?
Please mark on the drawings below the areas where you feel your pain.



When did your current injury or problem start?_____

_____

What activities are you unable to perform because of your current injury or problem?____

_____

Please list previous surgeries and approx. dates: _____

_____

Please list the medications you are currently taking: _____

_____

Please list allergies here:_____

_____

Height:_____ ft._____ In. Weight: _____ lbs.

Please circle the appropriate answer for your medical history:

Chest pain	*Yes*	*No*	Diabetes	*Yes*	*No*
Shortness of breath	*Yes*	*No*	Night sweats	*Yes*	*No*
Pain that wakes you in the night	*Yes*	*No*	Osteoporosis	*Yes*	*No*
Presence of non-healing wound	*Yes*	*No*	Currently pregnant	*Yes*	*No*
Obvious change in wart or mole	*Yes*	*No*	Current fever	*Yes*	*No*
Thickening or lump in breast	*Yes*	*No*	Any heart trouble	*Yes*	*No*
Feeling of pain or numbness in the groin	*Yes*	*No*	Epilepsy	*Yes*	*No*
Change of bladder or bowel control	*Yes*	*No*	Pacemaker	*Yes*	*No*
Recent significant weight loss	*Yes*	*No*	Metal implants	*Yes*	*No*
Smoker	*Yes*	*No*	Implanted Devices	*Yes*	*No*
Dizziness or light headed	*Yes*	*No*	Rheumatoid Arthritis	*Yes*	*No*
Abdominal pain	*Yes*	*No*	History of Cancer	*Yes*	*No*
I have fallen in the last year	*Yes*	*No*			

Please list any other medical history that is not listed above:_____

_____