Stride Physical Therapy

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Medical History Intake Form

Please take a few minutes to answer the following questions about your health and lifestyle to assist us in expediting your evaluation:

Date:____/___/___Patientõs Name:_____

Physician:_____Follow up appointment with physician: _____

Age: _____ Height: _____ Weight: _____

Reason for coming to Physical Therapy: _____

_____

When did your symptoms begin?_____

Is this resulting from (circle one): Accident Recent Surgery Sudden Onset Injury

Diagnostic Tests (circle all that apply): X-rays MRI CT-Scan Where?_____

Do you have or have you ever had any of the following (check all that apply):

☐ Diabetes ☐ High Blood Pressure ☐ Heart Problems
☐ Heart Attack ☐ Lung/Respiratory Problems ☐ Cancer
☐ Osteoarthritis ☐ Rheumatoid Arthritis ☐ Asthma
☐ Bladder Dysfunction ☐ Allergies:_____
☐ Other: _____

Do you currently take any medication on a regular basis (please list)? _____

_____

Have you ever received physical therapy before (circle one): Yes No

If so, where? _____ When?_____

For what condition: _____ Result of therapy:_____

Living conditions (check all that apply):

☐ Apartment ☐ House ☐ Multiple Family Dwelling

☐ Flights of stairs: #_____ ☐ Railing on stairs: right side left side both sides

☐ Elevator ☐ Live Alone ☐ Live with family

☐ Live with others

Occupation:_____Currently working? (circle one): Yes No

Please describe any pain using the following:

Location:_____

What makes your pain worse? _____

What makes your pain better? _____

What time of day is your pain the worst? _____

Description (circle all that apply): Sharp Dull Ache Tingling Numbness Radiating

Rate your pain on a scale of 0-10 where 0 is no pain, 10 is the worst pain you have ever felt:

0 1 2 3 4 5 6 7 8 9 10 ☐ Constant ☐ Intermittent

Does this pain prevent you from sleeping or does it wake you up in the middle of the night? Yes No

What activities do you feel that you cannot participate in because of this pain or condition? _____

_____

What are your goals and/or expectations for Physical Therapy? _____

_____

Please describe your pain (select all that apply):

- Dull pain
- Tingling
- Numbness
- Radiating
- Sharp
- Stabbing
- Ache
- Burning