CONE HEALTH
Rehabilitation

Patient Name: _____

Patient DOB: _____

Physical Therapy History Intake Form

Referring MD: _____ **Family MD**: _____

HISTORY:

1. **What** is your reason for coming to therapy today? _____

_____

2. **When** did your problem begin? _____

_____

3. **How** did your problem start? _____

_____

4. ***Please circle the appropriate answer:***

Therapist Comments

a) Do you have high blood pressure? **Yes** **No**

b) Do you currently have an infection? **Yes** **No**

c) Do you have diabetes? **Yes** **No**

d) Do you currently have heart trouble? **Yes** **No**

e) Do you have asthma? **Yes** **No**

f) Do you currently have osteoporosis? **Yes** **No**

g) Do you currently have active cancer? **Yes** **No**

h) Are you pregnant? **Yes** **No** **NA**

i) Do you have other health problems? **Yes** **No**
If yes, please list: _____

j) Is there anything that your doctor told you not to do? **Yes** **No**
If yes, please list: _____
_____

k) Are you currently taking any prescription or over-the-counter drugs? **Yes** **No**
If yes, please list: _____
_____

l) Are you currently taking any herbal preparations / vitamins? **Yes** **No**
If yes, please list: _____
_____

m) Are you allergic to adhesives/tape, latex, or bee stings? **Yes** **No**
If yes, please list: _____

n) Have you had any surgeries? **Yes** **No**
If yes, please list: _____
_____

o) Have you had physical therapy previously for the same problem? **Yes** **No**

p) Are you receiving other treatments for this problem at this time? **Yes** **No**
If yes, please list: _____
_____

q) What kind of tests have been done for your **current** problem? (*check if applicable*)

☐ **MRI** ☐ **X-Ray** ☐ **CT Scan** ☐ **Myelogram**

Or List: _____

Results: _____

r) Have you been hospitalized in the past year **for this condition**? **Yes** **No**
If yes, when and for how long?: _____

PLEASE COMPLETE PAGE TWO

CONE HEALTH
The Network for Exceptional Care

Patient Name: _____

Patient DOB: _____

s) Does anyone come to your home to provide health care needs (nursing, social work, physical/occupational/respiratory needs)? **Yes** **No**

t) Do you have any metallic implants (i.e. pacemaker)? **Yes** **No**
If yes, please list?: _____

5. When is your next appointment with the doctor who sent you to us? _____

6. PAIN:

1. Do you have pain now? □ No □ Yes, Location/Type: _____

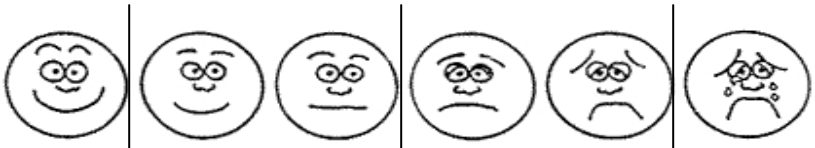
What makes it better? _____

What makes it worse? _____

Does the pain interfere with your daily life? □ No □ Yes, Describe: _____

RATE YOUR PAIN ON A SCALE OF 0-10 (0 BEING NO PAIN AND 10 BEING THE WORST)

_____/10 Today
(see scale below)



0 **1-2** **3-4** **5-6** **7-8** **9-10**

NONE **MILD** **MODERATE** **SEVERE**

7. BALANCE:

1. Have you fallen in the last 6 months? □ Yes □ No How many times? _____

2. Have you had a decrease in your activity level because of a fear of falling? □ Yes □ No

3. Are you reluctant to leave your home because of a fear of falling? □ Yes □ No

What are your goals as a result of attending physical therapy?

Please check appropriate box.

- ☐ Decrease pain
- ☐ Less difficulty with work activities
- ☐ Sleep longer _____ hours
- ☐ Improve movement
- ☐ Return to recreational activities / sports
- ☐ Anything else: _____
- ☐ Improve strength
- ☐ Stand longer ___ minutes / hours.
- ☐ Sit longer ___ minutes / hours.
- ☐ Less difficulty with home activities

Physical Therapist Signature: _____ **Date:** _____