The Manual Touch Physical Therapy

Medical Intake

Name: ____ **Date:**_________________**Age:**_______

Who referred you to our office?____

Diagnosis &/or your main complaint/symptoms, briefly describe:_________________________

____

____

Any recent test results for this condition (i.e. x-ray, MRI):________________________________

____

Date of onset of injury or symptoms:____

Briefly describe how this injury or symptoms began:_____________________________________

____

____

Are your symptoms/pain: (please circle) constant intermittent (comes & goes)

Dependent on position or activity (be specific)___________________________________

____

____

____

What activities can't you do because of your pain/symptoms:_____________________________

____

____

What is your occupation?____

Are you currently working?____________________________

Do you smoke cigarettes? (circle) YES NO ______packs/day X ______years

Do you drink alcoholic beverages? (circle) YES NO _______/week

Do you drink caffeinated beverages? (circle) YES NO ___________/week

Past Medical History: please check any that pertain & elaborate as needed

- Alcoholism
- Allergies
- Arthritis
- Asthma
- Autoimmune disease (be specific)
- Back Pain
- Cancer
- Chronic Fatigue
- Circulatory problems
- Depression
- Diabetes
- Dizziness/vertigo
- Drug Addiction
- Eating disorder
- Environmental sensitivities
- Eyes, ears, nose, throat problems
- Fibromyalgia
- Food intolerance (be specific)
- Fractures (be specific)
- GI issues (be specific)
- Headaches
- Heart Disease
- HIV
- High blood pressure
- Kidney or Bladder issues
- Learning Disabilities
- Liver or Gallbladder disease
- Lymphedema
- Mental Illness
- Musculoskeletal problems
- Neurological disorder
- Osteopenia/osteoporosis
- Respiratory problems
- Seizure disorder
- Skin problems
- Stroke
- Swelling
- Thyroid
- Traumatic brain injury (TBI)
- MEN: Prostate issues
  - other
- WOMEN: Menstruation issues
  - Endometriosis
  - Fibroids/cysts
  - other

List all traumas & when they occurred:____

____

____

List all surgeries & when they occurred:____

____

____

____

Do you exercise? YES NO

If yes, how often?________________

What kind of exercise?____

Are you on any kind of special diet or have food restrictions?____________________________

____

Stress level on a scale of 0 – 10 (0 is the lowest)_______________________________________

Sources of stress:____

Medications:____

____

____

Supplements:____

____

____

Please list 3-5 goals for physical therapy:

1.____

2.____

3.____

4.____

5.____

The Manual Touch Physical Therapy

	Frequency			Severity		
	Occasional	Often	Constant	Mild	Moderate	Severe
Dizziness, light-headed						
Pass out easily (faint)						
Decreased concentration						
Short term memory loss						
Slurred speech						
Balance or coordination problems						
Headaches						
Nausea						
Indigestion						
Difficulty swallowing						
Ears: ringing, stuffy, painful						
Vision: blurring, burning, aching, pressure, change, double						
Drooping eyelid or any changes in your pupils						
Allergies						
Sinus problems						
Nagging cough, hoarseness						
Chest Pain						
Cold hands						
Cold feet						
Stiffness						
Bowel problems						
Unusual bleeding or discharge						
Sexual function problems						
Change in any wart or mole						
Sore that does not heal						
Thickening in your breast/elsewhere						
Snore						
Pain wakes you from a sound sleep						
Night sweats						