the manual touch
PHYSICAL THERAPY
WHOLE BODY APPROACH TO HEALTH

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)_____

_____

_____

Rate your pain from 0-10; 0=none, 10=worst:_____

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._____

	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						