Finger Lakes Physical Therapy P.C.

Medical Intake Form

List all Current and Prior Medical Conditions

Physical Therapist Notes/Comments:

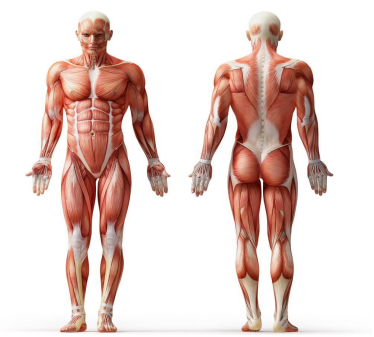
Allergies: Seasonal/Medication/Latex/Tape **Yes/No**
Arthritis: Osteo/Rheumatoid/Psoriatic **Yes/No**
Asthma/Breathing Problem/COPD **Yes/No**
Cigarette History **Yes/No**
Currently Pregnant **Yes/No**
Depression/Other Psychiatric Illness **Yes/No**
Epilepsy/Seizures **Yes/No**
Poor Circulation **Yes/No**
Swollen Feet **Yes/No**
Ulcers **Yes/No**
Thyroid Disease **Yes/No**
Headaches/Migraines **Yes/No**
High Blood Pressure **Yes/No**
High Cholesterol **Yes/No**
Diabetes **Yes/No**
Osteoporosis **Yes/No**
Heart Disease/Attack/Pacemaker/Arrhythmia **Yes/No**
Recent Chest Pain **Yes/No**
Cancer **Yes/No**
Stroke **Yes/No**
Scoliosis (Curved Spine) **Yes/No**
Fractures **Yes/No**
Metal Implants/Total Joint Replacement **Yes/No**
Prior Auto Accident **Yes/No**
Prior Work Accident **Yes/No**
Prior Surgeries **Yes/No**

Please describe your current injury/complaint:_____

Have you received Physical Therapy for this before: Yes/No If yes how long ago:_____

Have you had any of the following changes in the last two months (Circle ALL that apply):
Nausea/Vomiting/Fever/Chills/Sweats/Weight Change/Numbness/Tingling/Weakness/Fainting/Dizziness/Night Pain/Bowel or Bladder Changes/Increased Stress (explain)_____

Please mark area of Pain



Pain Description
Circle** all that apply
Dull Throbbing Intermittent
Numb Constant Tingly
Sharp Stabbing Searing
Burning Shooting Achy

Pain Levels (within the last week)
Scale is 0-10 0=No Pain 10=Worst Imaginable
Current:_____
Worst:_____
Best:_____

Height:_____ **Weight:**_____

Name:_____ Date:_____