Triumph
Physical Therapy & Wellness Center

Physical Therapy Intake Form

Personal Information

Name: ______________________ Date: ______________

Address: ______________________________________

Phone: ______________________ Email: ______________

DOB: ______________________ Sex: ______________

Who referred you? ______________________________

History

Exercise Frequency: ______________ Exercise Type(s): ______________

Do you smoke? __________ Have you ever smoked? __________ How Often? __________

Are you pregnant? ______________ Do you have a Pacemaker? ______________

Allergies: ______________________________________

What medications are you currently using? ______________________

Previous complaints/surgeries: ______________________

Previous diagnoses/medications: ______________________

Complaint

** Please Answer Every Question to the Best of your Ability

What is your major complaint? ______________________

Start Date: ______________ Possible Cause: ______________

Symptoms: ______________________________________

Previous doctors seen for complaint: ______________________

Previous treatment for complaint: ______________________

Symptom-Aggravating Factors: ______________________

Symptom-Relieving Factors: ______________________

Time of Day Symptoms are Best: __________ Time They Are Worst: __________

Current Duration of Pain: ☐ Intermittent ☐ Constant ☐ With Certain Motions

Current Level of Pain: ☐ Mild ☐ Moderate ☐ Severe ☐ Excruciating

Is your pain getting better or worse? __________ Have you had this injury before? __________

Do You Have Any of the Following Today? (Check All That Apply)

☐ AIDS/HIV	☐ Anemia	☐ Angina	☐ Arteriosclerosis
☐ Arthritis	☐ Asthma	☐ Blood Clots	☐ Bone Infection
☐ Cancer	☐ Chemical Dependency	☐ Circulation Problems	☐ Depression
☐ Diabetes	☐ Epilepsy	☐ Eye Infection	☐ Heart Problems
☐ Hemophilia	☐ High/Low Blood Pressure	☐ Joint/Bone Infection	☐ Liver Problems
☐ Lung Issues	☐ Multiple Sclerosis	☐ Musculoskeletal Problems	☐ Pneumonia
☐ Stroke	☐ STD	☐ Tuberculosis	☐ Urinary Infection

Mark Areas of Discomfort

______________________ ______________________ ______________

Signature of Patient / Representative — Printed Name — Date

Description of Personal Representative’s Authority: ______________________