RAINIER FAMILY
physical therapy, ps

INTAKE FORM

Please take a few moments to complete this worksheet. This information will help us in providing your care.

Name:_____ Primary Doctor:_____ Referring Doctor:_____

Age:_____ Reason for coming to PT:_____

Whom may we thank for referring you to RFPT? ☐ Internet ☐ Your Doctor ☐ Friend/Family ☐ Who:_____

Please indicate any medical history (cardiovascular, neurological, cancer, respiratory, FM, osteoporosis, etc)_____

_____

_____

Current Employment Status:

☐ Employed
- ☐ Part-time
- ☐ Full time

☐ Self-employed

☐ Retired

☐ Not working due to pain
Date last worked:_____

☐ Applied for Disability

☐ Unemployed

Occupation:_____

With whom do you live?

☐ Self ☐ Parents
☐ Spouse ☐ Friend(s)
☐ Children ☐ Other:_____

Previous Surgeries: Please List ALL (use back side if necessary)

_____

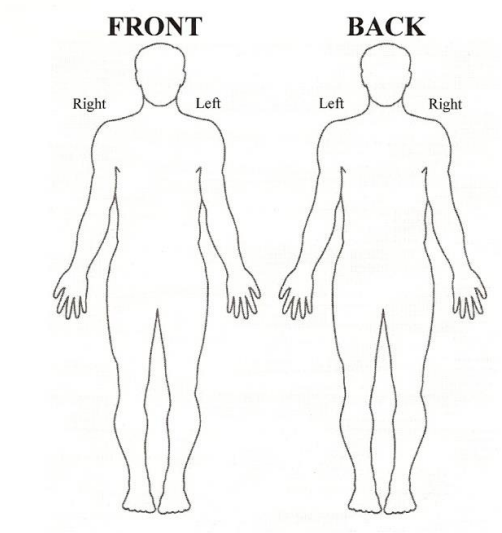
_____

_____

_____

Tests:	Date:	Result:
MRI	_____	_____
CT Scan	_____	_____
X-rays	_____	_____
Bone Scan	_____	_____
Bone Density	_____	_____
Other	_____	_____

On the diagram, please indicate areas where you have pain:



Medications: Please list ALL (including over-the-counter):

_____

_____

_____

Please check the box if you currently have any of the following:

☐ Fever, weight loss, sweats
☐ Cough, sputum productions, wheeze
☐ Shortness of breath
☐ Weakness or paralysis of arms or legs
☐ Headaches – how often?_____
☐ Dizziness, vision changes, light-headedness
☐ Swelling or rash
☐ Abdominal pain
☐ Change in bowel habits, nausea
☐ Chest pains, palpitations
☐ Easy bruising, bleeding, using blood thinners
☐ Change in bladder habits (frequency, pain)
☐ Pregnancy (or possibly pregnant)

What treatments have you tried for your problem?

☐ Exercise	☐ Massage	☐ Chiropractor
☐ Acupuncture	☐ Brace	☐ Physical Therapy
☐ Hot Pack	☐ Ice Pack	☐ Nerve Block
☐ Biofeedback	☐ TENS unit	☐ Traction
☐ Psychologist	☐ Psychiatrist	☐ Surgery
☐ Radiation	☐ Chemotherapy	☐ Ultrasound
☐ Compression Bandage	☐ Compression garment	☐ Other_____

On a scale of 0 to 10, how would you rate your pain?
(0 being no pain, 10 being worst imaginable pain)
The worst it gets:_____ The best it gets:_____
On average:_____

Please describe your pain (ie shooting, cramping, throbbing)

_____

_____

_____

What makes the pain better?_____

_____

What makes the pain worse?_____

_____