General Intake Form

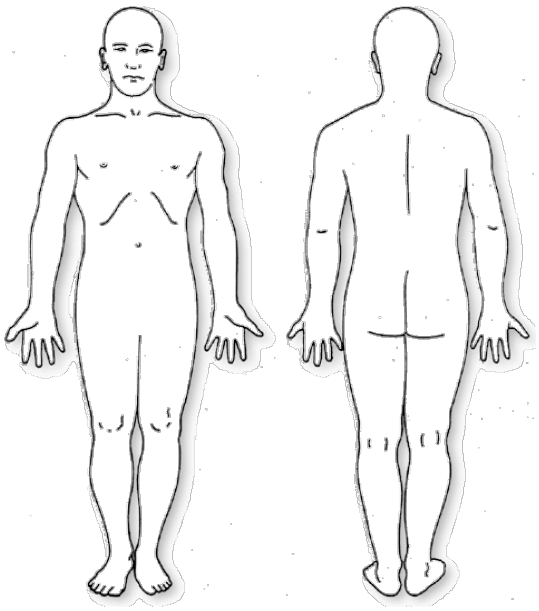
Describe why you are coming to physical therapy: _____
_____
_____

Date of injury, onset, accident, or surgery: _____
Nature of symptoms: _____
_____
_____

If you have pain, please rate your pain on a 0 to 10 scale. Indicate pain at its best, worst and usual: (circle & indicate appropriate numbers)

0	1	2	3	4	5	6	7	8	9	10
(no pain)										(ER pain)

Please Indicate on diagram where you have concern/pain/discomfort



What aggravates your issue/pain?
_____
_____

What eases your issue/pain?
_____
_____

What functional limitations do you experience?
Walking Sitting Sleeping Lifting Other_____

Please describe all prior surgeries:_____
_____
_____

Please list all medications you are currently taking:_____
_____
_____