TRINITY
PHYSICAL THERAPY

Patient Intake Form

Name: _____ Today's Date: _____

Date of Birth: _____ Date of Onset of Symptoms: _____

Please answer the following:	Y	N	Date	Please answer the following:	Y	N	Date
Are you currently under a doctor's care?				Do you have arthritis?			
Have you had any recent infections?				Do you have any artificial limb or joint?			
Have you ever been diagnosed with cancer or had any tumors?				Do you have chronic neck, back, joint, or muscle pain?			
Are you pregnant?				Have you been diagnosed with a disc herniation?			

Please answer the following:	Y	N	Date	Please answer the following:	Y	N	Date
Have you ever had a heart attack?				Do you get severe headaches or migraines?			
Have you ever been diagnosed with diabetes?				Do you have epilepsy or get seizures?			
Have you ever been diagnosed with a deep vein thrombosis (DVT)?				Have you ever had vertigo or loss of balance?			
Do you have varicose veins?				Have you ever fallen?			

Please answer the following:	Y	N	Date	Please list surgical history below:	Date
Do you have high blood pressure?					
Do you get tingling or numbness into hands and feet?					
Do you experience edema or swelling in any area of your body?					
Do your hands or feet always feel cold?					

List any other diagnosed illnesses:

List Medications

Notes:

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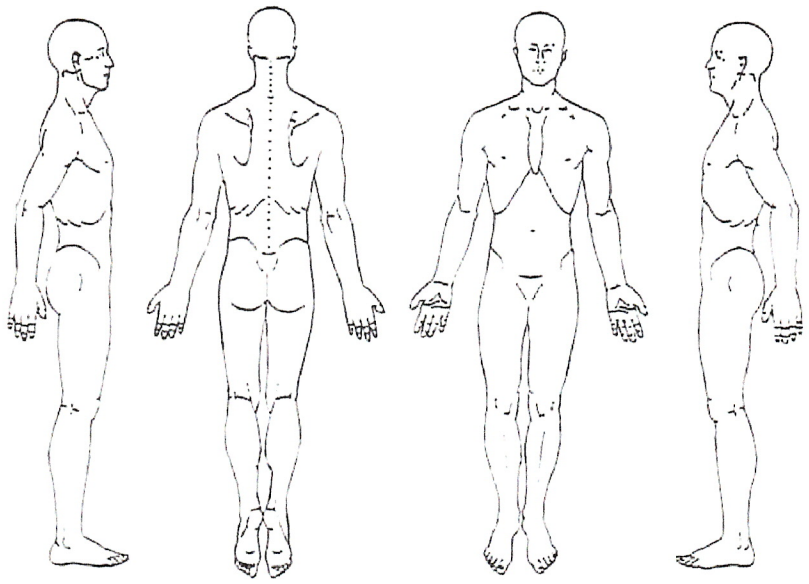
Name: _____ **Date:** _____

Please use scale below to mark on the diagram the type of pain and where you are experiencing it

D - Dull pain
T - Tingling
N Numb
- Burnin
S Stabbing/cutting
- Cramping



Please Mark on the line below to indicate your CURRENT pain level & your WORST pain level:

No Pain _____ **Worst Pain**

0 2 4 6 8 10

Please place a checkmark in the appropriate box regarding your health habits:

	None	Little	Moderate	A Lot
Exercise				
Sleep				
Alcohol Use				
Tobacco Use				
Drug Use				