Today's Date: MM/DD/ YYYY

Beauregard Health System Rehabilitation Services
Physical Therapy Intake Form

Patient's Name: ____ Date of Birth: MM/DD/ YYYY

Age: ____ Gender: Male ☐ Female ☐ Primary Care Physician ____

Are you currently receiving **Home Health Care** or any other assistance in the home?

☐ Yes; Name of Agency: ____ ☐ No

What is the reason for your visit today?

When was your last physician/medical visit for this problem? ____

When is your next follow-up appointment for this problem? ____

Have you had any X-Rays, MRI's or any other imaging examinations for this problem? ☐ Yes ☐ No

If Yes, Where? ____ When? ____

Previous Therapy: ____ Operations and Dates: ____

Please List Current Medications: ____ Allergies to Any Medications: ____

IF YOU HAVE ANY OF THE FOLLOWING CONDITIONS, PLEASE MARK BELOW

CONDITION	MARK "X"	CONDITION	MARK "X"
Diabetes		Kidney Disease	
High Cholesterol		High Blood Pressure	
Arthritis		Stomach Problems	
Stroke: DATE ___________		Intestinal Problems	
Brain Injury / TBI: DATE ___________		COPD / Emphysema	
Asthma		Heart Disease	
Congestive Heart Failure (CHF)		Pacemaker / Defibrillator	
Gout		Phlebitis (Blood Clots)	
Thyroid Problems		Hepatitis	
Ulcers		Hiatal Hernia	
Cancer: TYPE: ___________		H.I.V.	
Back Problems: TYPE ___________		OTHER: ___________________________	
OTHER: ___________________________		OTHER: ___________________________	

Comments: ____

FRONT and BACK, please

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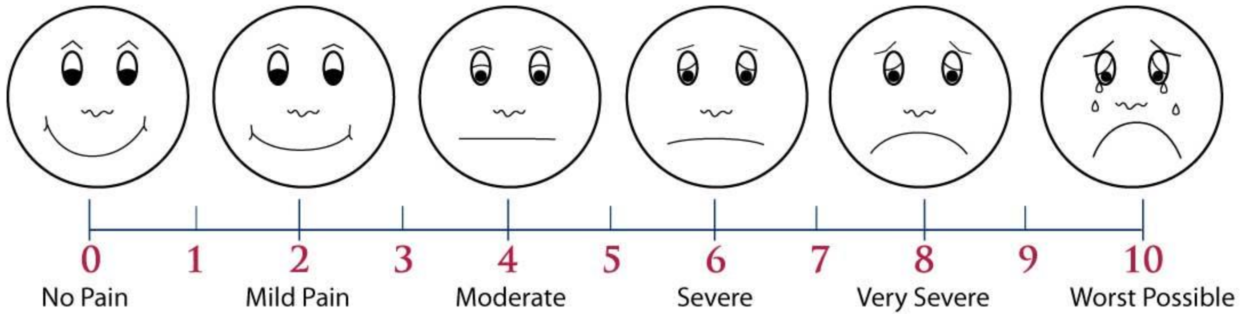
Physical Therapy Intake Form

PLEASE DESCRIBE YOUR PAIN BELOW:

What is your level or scale of pain? (**Circle Number**)



Frequency of Pain: (**Mark Below**)

- ☐ Constant
- ☐ Intermittent
- ☐ Off / On
- ☐ Other: ____________________________

What Increases Pain?

What Decreases Pain?

Description of Pain (**Mark Below**)

- ☐ Aching
- ☐ Burning
- ☐ Sharp
- ☐ Stabbing
- ☐ Shooting
- ☐ Numbness
- ☐ Tingling
- ☐ Throbbing
- ☐ Other: _____________

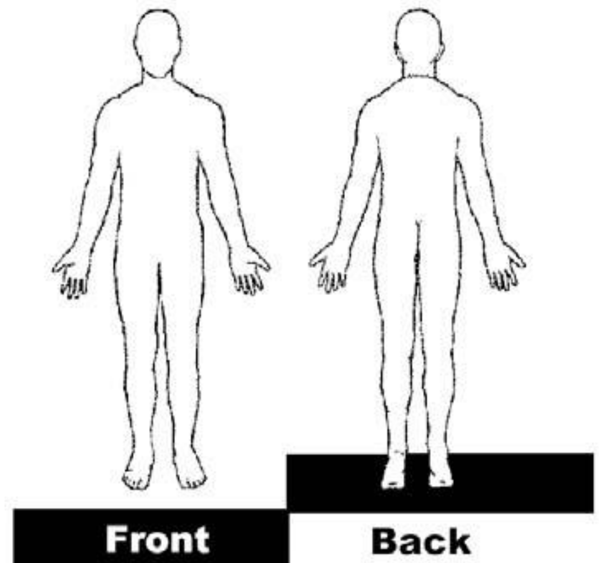
Pain Location:

Describe location

How Did the Pain Start?

Date of Injury?

If there is not a specific date or injury, approximately how long have you had the pain?



(Mark Above with an 'X')

FRONT and BACK, please