TO THE CORE
Physical Therapy & Conditioning, LLC
www.tothecorept.com

Intake and Past Medical History Form

Patient Name:____ **Date:**______________
Parent/guardian: ____
Address: ____
Home Phone: ______________________________ **DOB:** ______________________________
Work Phone: ______________________________ **Cell:** ______________________________
Emergency contact: __________________________ **Ph#:** ______________________________
Physician:________________________________ **Diagnosis:**___________________________

Occupation/Work Status:

What is your occupation?____
Are you presently working? ☐ Yes ☐ No If yes, ☐ Full-time ☐ Limited Duty
Explain:____
Lost days from work to date:__________ Days of work restriction to date:__________

Social History/Interests/Living Environment:

Do you live: ☐ Alone ☐ With spouse ☐ With family Other__________________
Do you have stairs? ☐ Yes ☐ No If yes, how many?_____ Do the stairs have a handrail? ☐ Yes ☐ No
How are your interests and/or hobbies affected by your symptoms and/or injuries?______________________________

Past Medical History/General Health/Prior Hospitalization:

How would you classify your general health? ☐ Good ☐ Fair ☐ Poor
Do you have, or have you had any of the following?

☐ Allergies	☐ Fibromyalgia	☐ Liver/Gallbladder Problem	☐ Recent Fractures
☐ Anemia	☐ Headaches	☐ Metal Implants	☐ Rheumatoid Arthritis
☐ Asthma	☐ Heart Attack	☐ Nausea/Vomiting	☐ Ringing in Ears
☐ Cancer	☐ Heart Disease	☐ Night Pain	☐ Seizures/Epilepsy
☐ Chest Pain/Angina	☐ Heart Palpitations	☐ Osteoarthritis	☐ Skin Abnormalities
☐ Depression	☐ Hernia	☐ Pacemaker	☐ Smoking History
☐ Diabetes I or II	☐ High/Low Blood Pressure	☐ Polio	☐ Stroke/TIA
☐ Dizziness/Fainting	☐ Hypoglycemia	☐ Pregnancy (current)	☐ Surgeries
☐ Fever	☐ Intolerance to Cold/Heat	☐ Kidney Problems	☐ Urine Leakage
			☐ Vision Changes

Is there any other history regarding your medical history that we should know?______________________

Medical Precautions/Contraindications:

Are there any factors that may complicate your ability to participate in therapy? ☐ Yes ☐ No
If yes, please explain:____
Have you fallen in the past 12 months? ☐ Yes ☐ No If yes, how many times?___________
If yes, please describe the nature of the fall(s) and if any injury(ies) occurred:______________________
____

Medications:

Please list all medications (with specific dosages) that you are currently taking, including over-the-counter, prescriptions, herbals, and vitamins/minerals.
____
____

Injury, Surgery, Current Problem:

Please indicate which body part you are seeking treatment for (PLEASE CIRCLE): R L

Neck Back Shoulder Elbow Hand/Wrist Hip Knee Ankle/Foot Pelvic Floor Other:_____________

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What is your date of injury/onset of symptoms?______________________

How and where did you injure yourself?____

____

Have you had any of the following? ☐ X-rays ☐ CT Scan ☐ MRI ☐ Other__________

Have you had any prior occurrences of this condition? ☐ Yes ☐ No

If yes, explain:____

What is your chief compaint?____

____

What makes your symptom(s) better?____

What makes your symptom(s) worse?____

Functional/ADL Restrictions: PLEASE COMPLETE ATTACHED FUNCTIONAL OUTCOME TOOLS

Prior Level of Function: What were you able to do prior to this injury that you are not able to do presently?

____

____

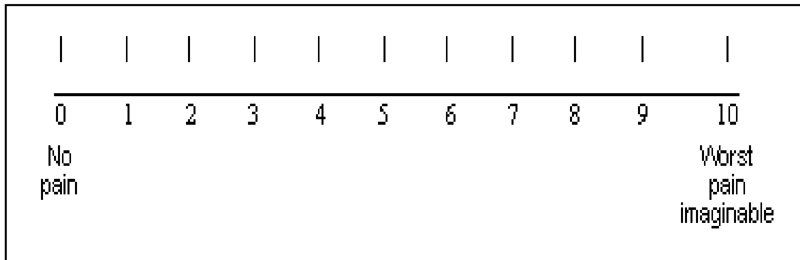
Pain Rating:

If you have pain, what is your pain level?
(0= No Pain, 10= Extreme Pain)

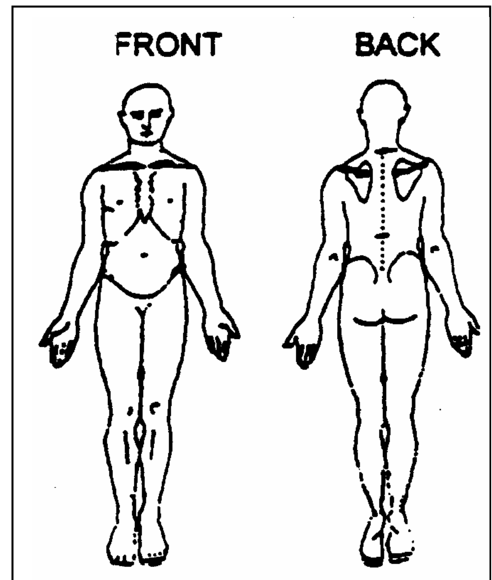
If you do experience pain, please describe your pain (ie: sharp, stabbing, ache, numbness, tingling, pins and needles, etc.)

____

____



Mark the location of your pain with an "X":



Patient's Goals for PT and/or Conditioning and Wellness:

What are your goals for participating in a therapy, conditioning and/or wellness program?

1. ____
2. ____
3. ____

To the best of my knowledge, I have fully informed you of the history of my problem and current status.

Next Doctor's Appointment: ______________________________

Patient and/or Guardian Signature:______________________________ **Date:**__________

Therapist Signature:______________________________ **Date:**__________