Lake Superior Physical Therapy

Intake & Systems Review Form

Patient's Name:	Birth Date:

Age:	Gender : ❑Male ❑ Female	Height:	Weight:

What is the reason for your physical therapy visit?

What is your primary concern and/or chief complaint?

What is the date your injury occurred?

Please list any physical limitations you are experiencing:

Your occupation:	Work Status: ❑ Part Time ❑ Full Time ❑ Unemployed ❑ Retired

If employed, what is your current duty level at work? ❑ Light ❑ Medium ❑ Heavy

Current living situation (Example: Live Alone, Home, Apartment, Etc.):

Recreational Activities/Sports/Play:

What is your pain level at its **worst**?:	(No Pain)	0	1	2	3	4	5	6	7	8	9	10	(Worst Pain)
What is your **current** pain level?:	(No Pain)	0	1	2	3	4	5	6	7	8	9	10	(Worst Pain)
What is your pain level at its **best**?:	(No Pain)	0	1	2	3	4	5	6	7	8	9	10	(Worst Pain)

Do you have any open wounds? ❑ Yes ❑ No	Please Describe:

Number of falls in the last year:

Please list any allergies:

Please list any diagnostic testing you have had preformed (Example: X-Rays, MRI, Etc.):

Please list **ANY** current medications you are taking (Prescriptions, Vitamins, Over The Counter, Etc.):

What are your goals for physical therapy?

Do You Have Trouble With:	Yes	No
Sleep		
Self Care		
Activities Of Daily Living		
Reaching/Pushing/Pulling		
Lifting/Carrying		
Sitting/Standing		
Bending/Squatting		
Mobility/Ambulation		
Community Access		

Aggravating Factors:	Yes	No
Sitting		
Standing		
Walking		
Stairs – Up		
Stairs – Down		
Sit To Stand		
Bending		
Voiding		
Laying		
Cough/Sneeze		

Have You Ever Had The Following:	Yes	No
Osteoarthritis		
Cardiovascular Disease		
Diabetes Mellitus Type 1		
Diabetes Mellitus Type 2		
Allergies		
Complicating Factors		
Previous Therapy		
Surgical History		

Women Only:	Yes	No
Do you have regular periods?		
Are you taking any type of birth control?		
Are you currently pregnant?		
Have you ever been pregnant?		
Total number of pregnancies:		
Total carried to term:		
Any complications?		

Benefits of Physical Therapy include but are not limited to: decreasing pain and inflammation; increasing range of motion, strength and functional mobility; and returning to activities of daily living, work, school, recreation and/or sports.

Substantial Risks of Physical Therapy include but are not limited to: burns, soft tissue injury, joint dislocations or sprains, fractures, swelling, cardiac/respiratory problems and allergic reactions.

We want you to be comfortable with our service and facility. If you have any questions or concerns please inform your Physical Therapist (PT) or the management. You have the right to refuse all or part of your treatment.

By signing I acknowledge I have read the above and attest that the information I have given is true to the best of my knowledge.

Patient's Signature:	**Date:**

By signing the physical therapist acknowledges that he/she has reviewed this patient's intake & systems review form.

PT Signature:	**Date:**

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