WHYoga
PHYSICAL THERAPY

INTAKE FORM

PERSONAL INFORMATION: *(Please print clearly)*

Name: _____
Last First Middle Initial

Home Address: _____
Street City State Zip

Telephone: H: ( ) _____ C: ( ) _____ W: ( ) _____

Date of Birth: _____ Sex: M / F Occupation: _____

Marital Status: S M W D Email: _____

Emergency Contact: _____ P: ( ) _____ Relationship: _____

MEDICAL INFORMATION:

Reason for Referral: _____

In general, your pain level is: 1 2 3 4 5 6 7 8 9 10
(please circle: 1 is low, 10 is high)

Referring Physician: _____ Phone: ( ) _____

Primary Physician: _____ Phone: ( ) _____

Please fill out these forms as specifically as possible to provide us with a clear picture of your present pain and functional status.

1. What is the primary complaint that brings you in for treatment today?

   Secondary complaint?

   As a result, I am now having difficulty with:

2. When and how did your symptom(s) begin? Date: _____

3. Have you ever received the following treatment for this condition?

	Yes	No	How Long?	Helpful?
Physical Therapy	_____	_____	_____	Yes No
Myofascial Release	_____	_____	_____	Yes No
Chiropractic	_____	_____	_____	Yes No
Acupuncture	_____	_____	_____	Yes No
Other: _____	_____	_____	_____	Yes No

4. Past Medical History (include dates of occurrence)

   Surgeries: _____

   _____

   Accidents: _____

   _____

5. List ALL medications which you are currently taking (include supplements, herbal and homeopathic remedies). Please include reason for medication.

_____

_____

6. Please place an "M" in front of each item that you experience at least MONTHLY. Place a "W" in front of each item that you experience WEEKLY or "D" for DAILY.

MUSCULO-SKELETAL:

_____	Headaches/migraines	_____
_____	Joint stiffness	_____
_____	Joint swelling	_____
_____	Spasms/cramps	_____
_____	Fractured bones	_____
_____	Strains/Sprains	_____
_____	Back/hip pain	_____
_____	Neck/shoulder pain	_____
_____	Arm/hand pain	_____
_____	Leg/foot pain	_____
_____	Jaw pain/TMJ	_____
_____	Tendonitis	_____
_____	Bursitis	_____
_____	Scoliosis	_____
_____	Arthritis	_____
_____	Osteoporosis	_____

CIRCULATORY/RESPIRATORY:

_____	Dizziness	_____
_____	Shortness of breath	_____
_____	Chest pain/tightness	_____
_____	Heart disease	_____
_____	Varicose Veins	_____
_____	Fainting	_____
_____	Cold feet/hands	_____
_____	Lymphedema	_____
_____	Excessing sweating	_____
_____	Sweaty palms	_____
_____	Blood clots	_____
_____	Allergies	_____
_____	Sinus condition	_____
_____	Asthma	_____
_____	Hi/Lo blood pressure	_____
_____	Diabetes	_____

DIGESTIVE/URINARY:

_____	Indigestion	_____
_____	Constipation	_____
_____	Diarrhea	_____
_____	Bowel irregularity	_____
_____	Liver Disease	_____
_____	Bloating/gas	_____
_____	Heartburn	_____
_____	Stomach cramps	_____
_____	Nausea/vomiting	_____
_____	Painful urination	_____
_____	Frequent urination	_____
_____	Urgent urination	_____
_____	Incomplete urination	_____
_____	Unable to hold urine	_____
_____	Kidney disease	_____

REPRODUCTIVE:

_____	Currently pregnant	_____
_____	Previous pregnancies	_____
_____	# pregnancies	_____
_____	# live births	_____
_____	# premature births	_____
_____	Periods	_____
_____	Irregular periods	_____
_____	Painful periods	_____
_____	PMS	_____
_____	Endometriosis	_____
_____	Menopause	_____
_____	Hot flashes	_____
_____	Breast lump/tender	_____
_____	Hysterectomy	_____
_____	Prostate condition	_____
_____	Impotence	_____

NERVOUS SYSTEM:

_____	Numbness/tingling	_____
_____	Twitching of face	_____
_____	Fatigue	_____
_____	Tired during day	_____
_____	Extreme fatigue	_____
_____	Chronic pain	_____
_____	Sleep Disorders	_____
_____	Epilepsy/Seizures	_____
_____	Stroke	_____
_____	Ulcers	_____
_____	Paralysis	_____

MISCELLANEOUS:

_____	Loss of appetite	_____
_____	Coughing	_____
_____	Stuffy nose, congestion	_____
_____	Vertigo/earache	_____
_____	Sore throat	_____
_____	Forgetfulness	_____
_____	Confusion	_____
_____	Hearing impaired	_____
_____	Difficulty concentrating	_____
_____	Visually impaired	_____
_____	Eyestrain	_____

M = MONTHLY W = WEEKLY D = DAILY

_____		_____	_____		_____
_____	Herpes/shingles	_____	_____	Blurry vision	_____
_____	Cerebral palsy	_____	_____	Eye irritation	_____
_____	Chronic fatigue synd.	_____	_____	Eating disorder	_____
_____	Multiple Sclerosis	_____	_____	Fibromyalgia	_____
_____	Muscular dystrophy	_____	_____	Cancer	_____
_____	Parkinson's disease	_____	_____	Infectious Disease	_____
_____	Spinal cord injury	_____	_____	Rashes	_____
			_____	Athlete's foot	_____
PSYCHOLOGICAL:			_____	Metal Implants	_____
_____	Unable to cope	_____	_____	Alcohol use	_____
_____	Easily annoyed/irritated	_____	_____	Nicotine use	_____
_____	Depression	_____	_____	Caffeine use	_____
_____	Anxiety	_____	_____	Uninterested in sex	_____
_____	Difficulty with family	_____	_____	Unable to enjoy sex	_____
_____	Difficulty with friends	_____	_____	Water retention	_____
_____	Worrisome thoughts	_____			
_____	Recurring bad thoughts	_____			
_____	Thoughts of suicide	_____			
_____	Fearful of people/places	_____			

7. If sleep is a problem, answer these questions:

Do you have trouble falling asleep? Yes No
Is your sleep restful? Yes No
How many times do you wake in the night? _____
How long before you fall back to sleep _____

8. Do you engage in regular exercise? Yes No

What type and how often? _____

_____

Are you able to exercise now? Yes No

Do you have discomfort, shortness of breath, or pain with exercise? _____

_____

9. In general, your lifestyle is: 1 Active 2 3 Average 4 5 Inactive

10. Patient Goals: List the activities that you would like to be able to do as a result of therapy.

	Activity	Duration/How Often	By When
1	_____	_____	_____
2	_____	_____	_____
3	_____	_____	_____

Other Goals? _____

_____

I have stated all medical conditions to the best of my knowledge and will update the therapist of any changes in my health status.

Client's Signature: _____ Date: _____