ROBA
PHYSICAL THERAPY
AND WELLNESS

MEDICAL HISTORY
INTAKE FORM

Primary Care Physician:_____ **Address & Phone Number:** _____

Describe your current problem and how it began:_____

_____

Onset Date: _____ **This problem is from:** *Sports: ____Work (fill out Worker's Compensation section if yes): _____*

Car Accident:_____Other:_____

Have you had surgery to address this problem? *Yes: ____No: _____ If yes, When, who was the surgeon:_____*

Have you had PT in the last 12 months? *No:____ Yes:_____ If yes, Approximately how many visits _____*

Describe the nature of your pain: *Sharp:_____Dull Ache: _____Shooting: _____ Tingling:_____ Other:_____*

My symptoms are present: *Constantly (76-100% of the day):____ Occasionally (26-50% of the day):_____*

Frequently (51-75% of the day): _____ Intermittently (0-25% of the day):_____

What makes your symptoms worse? *Sitting for ___ mins: _____ Standing for ___ mins: ___ Walking for __mins: ____*

Stairs: _____ Lying Down: _____ Standing up from a chair: _____ Reaching overhead: _____ Reaching behind back:_____

Other:_____

What makes your symptoms better? *Sitting: ____Standing: ___ Lying down: ____ Walking: ___ Massage: ___*

Chiropractor: ____ Ice: ____Heat: ____Rest: _____Other:_____

***Current Pain** (0-10):_____ **Pain at Worst** (0-10):_____ **Pain at Best** (0-10):_____*

How is your condition changing: *Getting better: ____ Getting worse: ____ Not changing: ____*

Who have you seen for this condition (please list name and phone #)?

Medical Doctor: _____Chiropractor: _____

Massage Therapist: _____ Physical Therapist: _____

Acupuncturist: _____ Other: _____

Have you had imaging (x-rays, MRI, CT Scan) for this problem? *No:____Yes (details):_____*

How would your rate your overall health right now? *Excellent:____Very Good: ___ Good: ____ Fair: ____ Poor: ____*

Do you exercise regularly? *No: ____ Yes: _____How often & what type? _____*

Recreational Activities/Hobbies: _____

Past Medical History: _____

Current Medications (name & dosage) _____

Prior injuries (injury & date): _____

Prior surgeries (type & date): _____

WORKER'S COMPENSATION INFORMATION *required for worker's comp claims

Worker's Compensation Company: _____ **Date of Injury:** _____

Adjustor's Name and Phone Number: _____ **Claim #:** _____

Do you have a physical therapy script from worker's comp doctor: *Yes: ____No: _____*