



Family Care Plus Physical Therapy & Wellness Patient intake form

Family Care Plus
Physical Therapy
& Wellness

Helping you heal, restore, and prevent

Name: _____

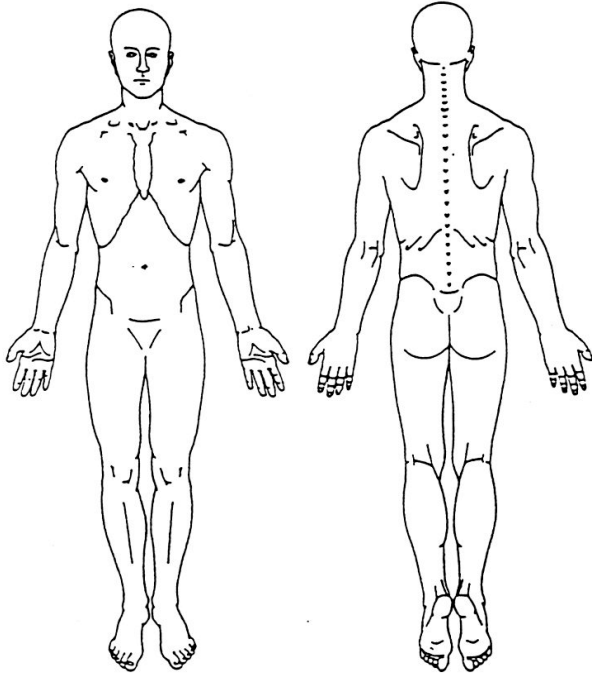
Occupation: _____

Are you currently working? Yes No

Date: _____

Please indicate when you had first noticed your current condition: _____

Please indicate on the body diagram your signs & symptoms related to your current condition.



Pleas mark:
X = for pain
O = for tingling
// = for numbness

Also, fee free to add any
comments you have:

Is your pain: Constant (present 24 hours) or Pain comes and goes (intermittent pain)

Do you have pain at night? Yes No

What helps to relieve your pain or symptoms? Medicine Rest Other: _____

How much medicine do you have to take to get relief? _____

List the top four activities, which you are unable to do or have difficulty with due to your current condition:

- _____
- _____
- _____
- _____

List of all the doctors involved with your care: _____



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Have you had any therapy for your current condition? Yes No

If yes, where and how long did you receive therapy?

Are you allergic to latex? Yes No

Do you smoke? Yes No

*Are you pregnant? (For female patients) Yes No

Medical History: Check (X)

	Yes	No		Yes	No
Epilepsy			Amputation		
Diabetes			Vision Impairment		
Heart problems			Hearing Impairment		
Pacemaker			Hemophilia/bleeding issues		
High Blood Pressure			Asthma		
Stroke			Emphysema		
Carpal Tunnel			Polio		
Multiple Sclerosis			Cancer		
Cerebral Palsy			Arthritis		

Other medical conditions not mentioned above : _____

Surgical history: List all surgeries

Type of surgery

Date of surgery

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

List of medications including joint injections and pain patches you have:

