Associated Physicians
Devoted Physicians, Trusted Care.

Intake Form

Are you a former CPT patient or a friend/family member of a former patient? ☐ ***Yes*** ☐ ***No***

I. Personal Information

Name: ____ Date:__________________

Occupation: ____________________________ Employer: __________________________

Describe your usual exercise routine:____

II. Medical History: Have you ever been diagnosed with or do you have any of the following conditions? (Check all that apply)

☐ **None of these apply to me**

- ☐ Cancer
- ☐ Heart problems
- ☐ Chest pain/angina
- ☐ Circulation problems
- ☐Blood clots
- ☐ Stroke
- ☐ Anemia
- ☐ Chemical dependency (i.e. alcoholism)
- ☐ Depression
- ☐ Anxiety
- ☐ Lung problems
- ☐ Tuberculosis
- ☐ Sexually transmitted disease/ HIV
- ☐ Rheumatoid Arthritis
- ☐ Arthritis
- ☐ Bladder/urinary tract infection
- ☐ Kidney problems/infection
- ☐ Cholesterol high/low
- ☐ Thyroid problems
- ☐ Diabetes
- ☐ Osteoporosis
- ☐ Multiple Sclerosis
- ☐ Epilepsy
- ☐ Hepatitis
- ☐ Ulcers
- ☐ Liver problems
- ☐ Allergies/asthma
- ☐ Pacemaker
- ☐ Blood thinners
- ☐ Fibromyalgia
- ☐ Broken bones
- ☐ Recent infection /illness (explain)
- ☐ Other

Past surgical history (list & date): ____

III. How did you hear about our clinic?

☐ My doctor's office ☐ I am referring myself for PT ☐ Family/friend/colleague recommended ☐ My insurance company said you were in my network ☐ I did a search on the internet ☐ My trainer ☐ Another PT sent me ☐ Other__________________

Please tell us who we can thank for sending you our way:____

IV. Current Symptoms Problem(s) you are here for: ____

What date (roughly) did your symptoms start? _______________________

Are your symptoms related to a work injury? Yes No Or a motor vehicle accident? Yes No

Treatments so far for this problem (injections, chiropractic, etc.): ____

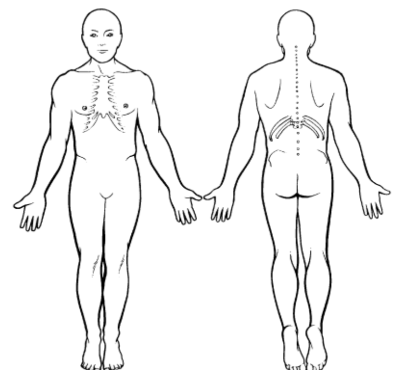
Have you had an X-ray, MRI, or other imaging for this problem? Yes No If yes, please list, including date: ___________

Have you ever had this before? Yes No

If yes, when and how it was treated: _______________________________

What is your personal goal for therapy? __________________________________

Body chart: Please mark **all** areas where you feel symptoms on the chart to the right



What makes your symptoms **better**? _______________________________

What make your symptoms **worse**? ________________________________

On the scale below, please mark the number which best represents the severity of your pain over the past 24 hours:

0	1	2	3	4	5	6	7	8	9	10
No Pain								Worst pain imaginable		

SINCE YOUR SYMPTOMS BEGAN, have you noticed any of the following?
(Check all that apply)

- ☐ Fatigue
- ☐ Generalized muscle weakness
- ☐ Pain at night
- ☐ Leg swelling
- ☐ Weight loss/gain
- ☐ Difficulty maintaining balance when walking
- ☐ Changes in bowel or bladder function
- ☐ Changes in cognition
- ☐ Skin changes
- ☐ Numbness or tingling
- ☐ Falls
- ☐ Shortness of breath
- ☐ Heartburn/indigestion
- ☐ Difficulty swallowing
- ☐ Headaches
- ☐ Changes in appetite
- ☐ Heart palpitations
- ☐ Fever/chills/sweats
- ☐ Nausea/vomiting
- ☐ Abdominal pain
- ☐ Fainting
- ☐ Cough
- ☐ Chest pain especially with sweats
- ☐ Other
- ☐ **None of these apply to me**

During the past month have you been feeling down, depressed, or hopeless? Yes No

During the past month have you been bothered by having little interest or pleasure in doing things? Yes No

Is depression or anxiety something you would like help with? Yes Yes, but not today No

Do you ever feel unsafe at home, or has anyone tried to hit or injure you in any way? Yes No

If you are over 65, how many falls have you had in the last 6 months? _____________

Are you taking any medications? ☐ No ☐ Yes ☐ Associated Physicians has my medications on file ☐ Med list is attached

Patient Signature:____