ALL THERAPY™
Physical Therapy & Wellness

Movement is freedom™

101 N. Broad Street
Middletown, DE 19709
(302) 376-5578 (b) * (302) 376-5580 (f)
www.ALLTherapy.net

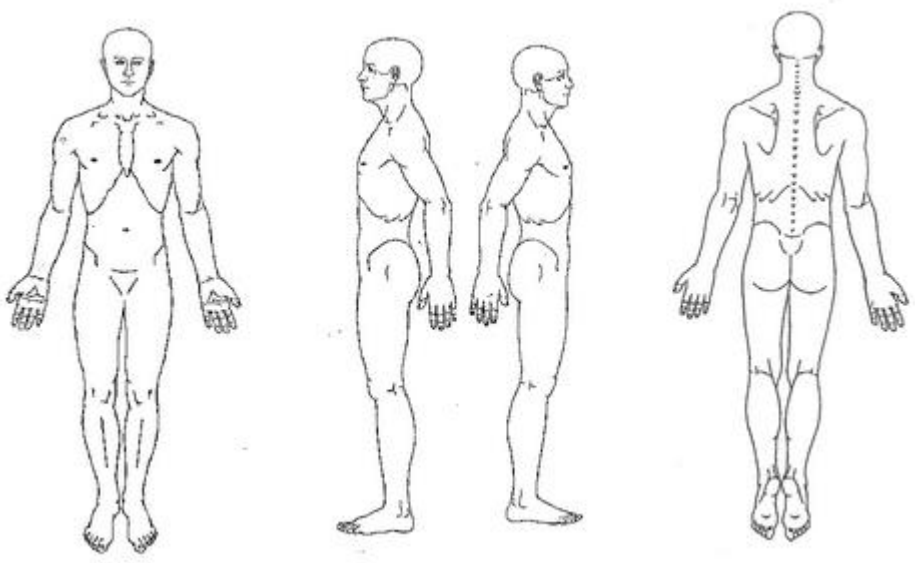
PATIENT INTAKE FORM

To ensure you receive a complete and thorough evaluation, please provide us with this important background information.

Name: _____ Age: _____

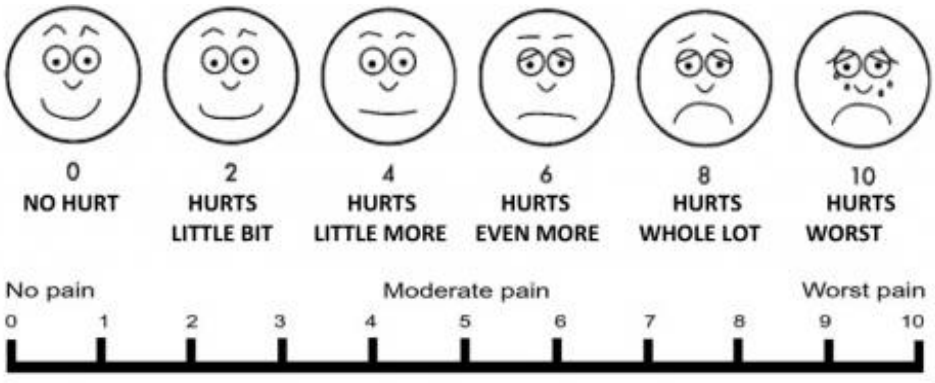
Occupation: _____ Diagnosis: _____

Do you have any pain? ☐ YES ☐ NO
If yes, please mark the areas on the diagram below.



WONG-BAKER FACES PAIN RATING SCALE

Mark with an 'X' on the face which best describes your current pain, and circle on the scale your worst pain level.



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Do you have other symptoms such as: ☐ swelling ☐ stiffness ☐ weakness ☐ limited motion ☐ tightness ☐ numbness ☐ tenderness ☐ tingling sensation

What makes your pain increase? _____

_____

What, if anything eases your pain? _____

_____

Due to your condition do you have difficulty?

☐ walking ☐ balancing ☐ sleeping ☐ dressing, etc. ☐ work duties ☐ getting up from bed/chair
☐ commuting ☐ light domestic duties ☐ recreational/sports activities ☐ heavy domestic duties

Current Medication: _____

_____

_____

Medical history (*Have you ever had any of the following*)?

___ Anemia	___ Fractures	___ HIV	___ Pacemaker
___ Asthma	___ Headaches	___ Insomnia	___ Rheumatoid Arthritis
___ Cancer	___ Heart Attack	___ Kidney Problems	___ Tuberculosis
___ Chest pain	___ Heart Disease	___ Low Back Pain	___ Seizures
___ Depression	___ Heart Palpitations	___ Low BP	___ Stroke
___ Diabetes	___ Hepatitis	___ Metal Implants	___ Swollen Ankles
___ Dizziness	___ Hernia	___ Osteoarthritis	___ Other (list below)
___ Fainting	___ High BP	___ Osteoporosis	_____

List any surgeries with dates: _____

_____

_____

What was your exercise program prior to your injury? _____

_____

_____

What are your goals? _____

_____

_____

How did you hear about ALL Therapy? _____

_____

_____