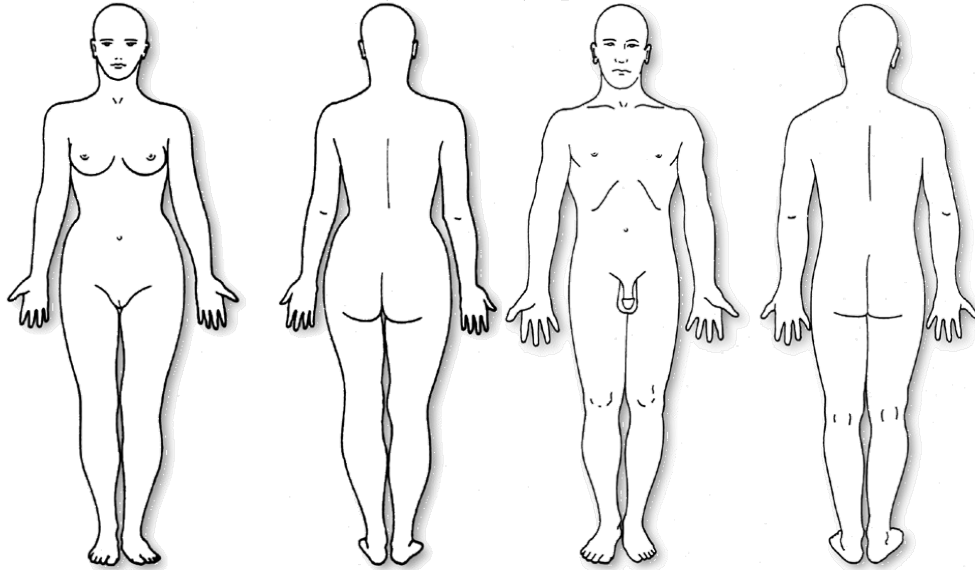
Back in Action PHYSICAL THERAPY 9377 E. Bell Rd. #101 • Scottsdale, AZ 85260 • (480) 513-4801

Clinical Intake Form- Please complete and fax to 480-513-4867, or bring with you to your visit.

Name:_______________________________________ **DOB:**_______

Reason for Visit:
____
____
__
When did your current symptoms begin? (month/day/year)____/_____/_____
Did you have a specific injury and if so please briefly describe:____
Have you ever had your current symptoms before?: ____
What makes your symptoms worse?: ____
What makes your symptoms better?: ____
Have you had any treatment for your current symptoms?: ____

Pain Description
Please shade the areas where you have symptoms:



Rate your current pain on a scale from by circling the corresponding number 0-10 (0= no pain; 10= requires emergency care)

	Current		Best		Worst
	10		10		10
	9		9		9
	8		8		8
	7		7		7
	6		6		6
	5		5		5
	4		4		4
	3		3		3
	2		2		2
	1		1		1
	0		0		0

Circle the words that most accurately describe your type of pain:

Shooting	Boring	Throbbing	Deep aching	Tingling
Dull	Burning	Stabbing	Sharp	Numbness

Personal Medical History: Please circle any of the following conditions which you currently have or have had:

	YES	NO
Osteoporosis		
Asthma		
Cancer		
Allergies		
Thyroid problems		
Apnea		
Chronic obstructive pulmonary disease		
Vascular diseases:		
High blood pressure		
Diabetes		
Arthritis (Rheumatoid/Osteo)		
Cardiac Problems		
Lung disease		
Kidney disease		
Liver disease		
Psychological/emotional problems		

Other Medical Problems: (Please list any other medical problems that have not been included)

____

____

__

Hospitalization/Operation: (Please list any hospitalizations or operations you have had & the date occurred)

Date Occurred

____ ____________

____ ____________

____ ____________

____ ____________

Medication: (Please list any medication you are currently taking and the dosage)

____

Current Medical Tests: (performed within the last 2 months)

____

____

__

Lifestyle:

Do you smoke?________. If Yes: How many packs do you smoke a day? _______________

How many caffeinated beverages do you consume per week? _____________________________________

Do you exercise on a regular basis? _________ Type of activity/exercise:_________________________
Number of hours per week spent in physical activity/exercise:__________________________________
Please rate your average stress level on a scale of 1-10 (0 = no stress, 10 = extreme stress):___________