PUYALLUP VALLEY PHYSICAL THERAPY

FRONT ONLY

PATIENT INTAKE FORM:

DO YOU HAVE: ALLERGIES _____ DIABETES_____ HIGH BLOOD PRESSURE _____

HIV/AIDS _____ LOSS OF FEELING _____ POOR CIRCULATION _____

SEIZURES _____ CANCER _____ HEART DISEASE_____PACEMAKER_____

HEPATITIS _____ ASTHMA _____ EMPHYSEMA _____

PERSONAL/FAMILY HISTORY OF ARTHRITIS _____

FEMALES: PREGNANT YES _____ NO _____

HAVE YOU HAD ANY FRACTURES, DISLOCATIONS, SURGERIES OR METAL IMPLANTS?

(PLEASE LIST AND INCLUDE DATES):____

ARE YOU TAKING MEDICATIONS? YES _____ NO _____

PLEASE LIST: ____

____

Circle the number that best describes your current pain level.

HEIGHT___________ **WEIGHT___________**

OCCUPATIONAL/PHYSICAL RESPONSIBILITIES: ____________________________________

HOW DID YOU LEARN OF THIS CLINIC? DOCTOR _____ FRIEND/RELATIVE _____

PHONE BOOK _____ OTHER ____

PATIENT'S SIGNATURE: ____________________________________DATE: _________________