DATE: _____

PATIENT: _____

willard PHYSICAL THERAPY

469.795.7865 PHONE • 469.795.7866 FAX • www.willardpt.com

INTAKE

WHAT IS THE PRIMARY PURPOSE FOR COMING IN TODAY? _____

WHEN DID SYMPTOMS BEGIN? _____

WHAT EVENT STARTED PAIN? _____

PRIMARY AREA(S) OF PAIN? _____

NATURE OF PAIN (CHECK ALL THAT APPLY): ☐ STABBING ☐ SHOOTING ☐ DULL ☐ ACHING ☐ PINS & NEEDLES ☐ NUMB ☐ CONSTANT ☐ OCCASIONAL

SECONDARY AREAS OF PAIN: _____

WHAT PERCENTAGE OF THE DAY IS PAIN FELT? _____

WHAT ACTIVITIES OR POSITIONS INCREASE YOUR PAIN? _____

WHAT DECREASES YOUR PAIN? _____

HAVE YOU HAD THIS PAIN BEFORE? (CHECK) ☐ YES ☐ NO

IF SO, HOW DID IT RESOLVE? _____

WHAT TREATMENTS HAVE YOU TRIED (PT, CHIRO, INJECTIONS, MEDICATIONS, ACUPUNCTURE, ETC.)?

_____

WHICH OF THESE TREATMENTS WERE HELPFUL? _____

DO YOU HAVE DIFFICULTY SLEEPING DUE TO PAIN? (CHECK) ☐ YES ☐ NO

DOES THE PAIN WAKE YOU AT NIGHT? (CHECK) ☐ YES ☐ NO

DOES COUGHING OR SNEEZING INCREASE YOUR PAIN? (CHECK) ☐ YES ☐ NO

PLEASE MARK ANY TESTS YOU HAVE HAD, DATES OF TESTS AND RESULTS IF YOU KNOW THEM.

MRI X-RAY EMG/NCV

_____

WHAT OTHER CONDITIONS ARE YOU CURRENTLY BEING TREATED FOR? _____

LIST MEDICATIONS AND WHAT CONDITIONS YOU ARE TAKING THEM FOR: _____

_____

LIST PRIOR SURGERIES AND GENERAL DATES OF SURGERY: _____

_____

E YOU CURRENTLY EMPLOYED? (CHECK) ☐ YES ☐ NO

IF SO, WHAT ARE THE POSTURES AND DEMANDS OF YOUR WORK? _____

WHAT ARE YOUR GOALS FOR TREATMENT? _____

DO YOU HAVE A TIMELINE IN MIND TO MEET YOUR GOAL? (CHECK) ☐ YES ☐ NO

IF SO, WHEN? _____

HOW DID YOU HEAR ABOUT WILLARD PHYSICAL THERAPY ASSOCIATES? _____