Patient Intake Form

COMBATATHLETES
PHYSICALTHERAPY

*Please fill out the information below completely and clearly before your PT evaluation.

Patient Name: ______________________________ Date: ____________________

Height: __________ Weight: ___________ Gender: Male / Female

Referring Type: Self / Physician / Others ______________________________

Occupation: ______________________________ Work Status: Full / Part Time

Hobbies: ______________________________

Nature of Injury:

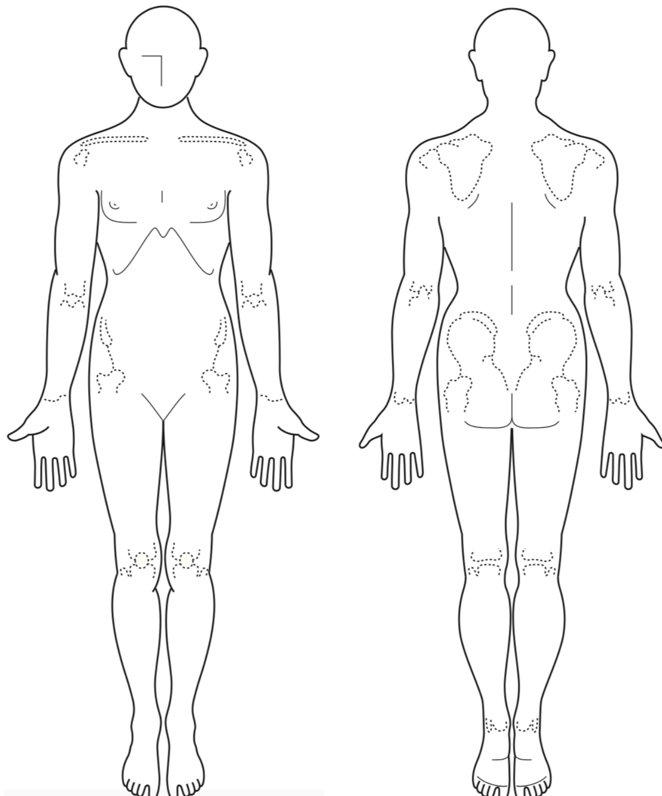
Work Related	Chronic	Fall	Motor Vehicle Accident	
Recreational	Trauma	Unknown	Surgery	Lift/Carry

What is your pain rating over the last 24 hours? 0-10 Numeric Pain Rating Scale

0 1 2 3 4 5 6 7 8 9 10

No Pain Worst Possible Pain

Please use the diagram below to mark where your current symptoms are:



Symbols to use:

Aching: XXX Stabbing: ///

Pins/Needles: OOO Burning: ∇∇∇

Numbness: - - - Radiating: →→→

My symptoms are made BETTER by:

____

____

My symptoms are made WORSE by:

____

____

My symptoms are:

Constant Intermittent Chronic New

Are your work or activities of daily living limited?

Yes Partially No