NYPT
NEW YORK PHYSICAL THERAPY

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MEDICAL HISTORY INTAKE FORM

Name:_________________________________ Date:__________________________

Height:______________ Weight (lbs.):_______________

Describe your current complaint:____

____

When did your condition begin? ____

How did your problem begin?____

Have you had this condition in the past? ☐ Yes ☐ No Have you had surgery? ☐ Yes ☐ No

List any past surgeries:____

Current level of pain (0=no pain, 10= severe pain)

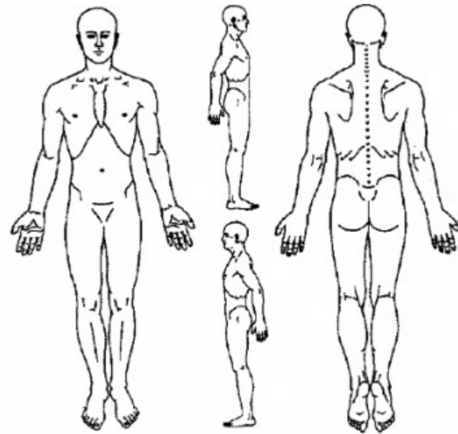
At rest: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

With Movement: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Type of symptoms: ☐ Sharp ☐ Shooting ☐ Burning ☐ Dull ☐ Throbbing ☐ Aching ☐ Cramping
☐ Stiffness ☐ Swelling ☐ Numbness ☐ Tingling ☐ Other:____________________

Since your condition began, have your symptoms: ☐ decreased ☐ not changed ☐ increased

Please mark your symptoms on the drawings to the right:
"X"= Pain/Tightness/Stiffness "O"= Numbness/Tingling



How often do you have the pain? (Please mark all that apply)

☐ Constant ☐ Intermittent ☐ Daily
☐ Weekly ☐ Mornings ☐ End of day

Does it interfere with your:

☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities that are painful to perform:

☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying down
☐ Sitting to standing

List all medications you are presently taking:____

____

Check any of the following that are in your health history: ☐ Asthma ☐ Shortness of Breath ☐ Heart Murmur ☐ Chest Pain
☐ Pacemaker ☐ High Blood Pressure ☐ Heart Attack ☐ Heart Surgery ☐ Stroke or TIA ☐ Blood Clot ☐ Epilepsy or Seizure
☐ Hyper/Hypothyroidism ☐ Emotional/Psychological ☐ Headaches ☐ Weakness ☐ Numbness/Tingling ☐ Dizziness or Fainting
☐ Multiple Sclerosis ☐ Weight Loss ☐ Allergies ☐ Cholesterol ☐ Neurological Problems ☐ Diabetes ☐ Metal Implant
☐ Cancer ☐ Smoking ☐ Arthritis ☐ Are you Pregnant? ☐ Osteoporosis ☐ Incontinence ☐ Hernia

Please list three goals you would like to achieve while in physical therapy:

1.____

2.____

3.____

Patient/Guardian Signature:____ Date:______________________