Tonic Physical Therapy
Patient Intake Form

Name ..... Date .....

Primary Care Physician .....

Have you RECENTLY noted any of the following? (check all that apply)

- ○ Changes in bowel or bladder function
- ○ Urinary Frequency, problems initiating or controlling bladder
- ○ Nausea/vomiting
- ○ Dizziness/lightheadedness
- ○ Difficulty maintaining balance while walking
- ○ Fever/chills/sweats
- ○ Fatigue
- ○ Poor general health
- ○ Weight loss/gain
- ○ Shortness of breath/cough/wheezing
- ○ Headaches
- ○ Changes in appetite
- ○ Heat/cold intolerance
- ○ Increasing thirst
- ○ Blurred Vision
- ○ Changes in Visual acuity

- ○ Ear pain, difficulty hearing
- ○ Sore throat/difficulty swallowing
- ○ Bruise easily, bleeding
- ○ Rashes/skin lesions, change in moles
- ○ Nasal congestion/ discharge/bleeding
- ○ Palpitations/low/high blood pressure
- ○ Diarrhea/constipation, abdominal pain/discolored stools
- ○ Pain at night
- ○ Weakness/fatigue
- ○ Difficulty swallowing
- ○ Depression, anxiety suicidal thoughts or attempts

Have you EVER been diagnosed with any of the following conditions? (check all that apply)

- ○ Cancer (type) .....
- ○ Heart disease
- ○ High blood pressure
- ○ Asthma
- ○ Allergies
- ○ Pacemaker inserted
- ○ Metal Implants
- ○ Osteoporosis
- ○ Chemical dependency (Ie: alcoholism)
- ○ Rheumatoid arthritis
- ○ Seizures
- ○ Headaches
- ○ Stroke
- ○ Depression
- ○ Anemia
- ○ Lung problems (Bronchitis , COPD)
- ○ Thyroid problems
- ○ Other .....

- ○ Diabetes
- ○ Multiple sclerosis
- ○ Kidney/liver problems
- ○ Stomach ulcers
- ○ Epilepsy
- ○ Parkinson's disease
- ○ Other .....

DO YOU SMOKE?

- ○ Yes ..... pack/day
- ○ No

For Women: Are you currently pregnant or thing you might be pregnant?

- ○ Yes
- ○ No

Please list current medications

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Are you currently taking blood thinning or anticoagulant medications for any medical condition?

- ○ Yes
- ○ No

Please list any **surgeries** or other conditions for which you have been hospitalized, including dates:

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Have you received any special tests related to the injury/condition?

- ○ MRI
- ○ CT Scan
- ○ X-Ray
- ○ Bone
- ○ Scan
- ○ Doppler
- ○ Other: .....

What is your CHIEF Complaint about your injury/symptoms/function?

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Pain at LOWEST: Rate your lowest pain level in the past 24 hours.

0	1	2	3	4	5	6	7	8	9	10
No Pain										**Worse Pain Imaginable**

Pain CURRENTLY: Rate your level of pain at this time.

0	1	2	3	4	5	6	7	8	9	10
No Pain										**Worse Pain Imaginable**

Pain at WORST: Rate your highest pain level in past 24 hours.

0	1	2	3	4	5	6	7	8	9	10
No Pain										**Worse Pain Imaginable**

List 1 Important activity you are unable or have difficulty performing as a result of your pain/symptoms. (circle number below)

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(ex. Stairs, reaching overhead, bending over)

0	1	2	3	4	5	6	7	8	9	10
No Pain										**Worse Pain Imaginable**

What is **your goal** for therapy at this time?

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Patient Signature ..... **Date**.....