MOMENTUM PHYSICAL THERAPY
Patient intake questionnaire

To insure you receive a complete and thorough evaluation, please provide us with the important background information on the following form. If you do not understand a question leave it blank and your therapist will assist you. Thank you!

PATIENT NAME: ______________________ Age: _________ Occupation: ______________________

Have you seen any of the following during the past six (6) months:

___ Medical Doctor (MD) ___ Osteopath ___ Dentist
___ Psychiatrist/Psychologist ___ Physical Therapist ___ Chiropractor

Please describe:_______________________________________

FOR WOMEN: Are you currently or think you might be pregnant? YES NO

Have you recently noticed:

Yes No Weight loss/gain
Yes No Nausea/vomiting
Yes No Fatigue
Yes No Weakness
Yes No Fever/chills/sweats
Yes No Numbness or tingling

Have you EVER been diagnosed as having any of the following conditions?

Yes	No	Heart Problems	Yes	No	Thyroid problems	Yes	No	Tuberculosis
Yes	No	High blood pressure	Yes	No	Diabetes	Yes	No	Kidney disease
Yes	No	Heart arrhythmia	Yes	No	Multiple sclerosis	Yes	No	Anemia
Yes	No	Stroke	Yes	No	Rheumatoid arthritis	Yes	No	Epilepsy
Yes	No	Circulation problems	Yes	No	Other arthritic conditions	Yes	No	Incontinence
Yes	No	Asthma	Yes	No	Depression	Yes	No	Cancer - Type: ______
Yes	No	Emphysema/Bronchitis	Yes	No	Hepatitis			Other:______

Please list any hospitalizations, include approximate date and reason for hospitalization:

DATE	REASON FOR SURGERY/HOSPITALIZATION
________	______________________________
________	______________________________
________	______________________________
________	______________________________

Please describe any significant injuries (including fractures, dislocations, sprains) and the approximate date of injury:

DATE	INJURY
________	______________________________
________	______________________________
________	______________________________
________	______________________________

Please list all OVER-THE-COUNTER medications you are currently taking:

____
____
____
____

Please list all **PRESCRIPTION** medications you are currently taking:

____
____
____
____

To the best of my knowledge, this information is complete and accurate.

Patient signature: ______________________________ Date: ____________________

Therapist signature: ______________________________ Date: ____________________