

# Patient Intake Form

Midwest Medical Center PT  
One Medical Center Drive, Galena, IL 61036

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
Age: \_\_\_\_\_ Occupation: \_\_\_\_\_

Chief Complaint: \_\_\_\_\_

Other tests or treatments you have received/are receiving for this injury (ex. Chiropractor, occupational therapy, x-rays, MRI, CTscan, bone density, etc.): \_\_\_\_\_

## PAST MEDICAL HISTORY

Have you ever had any of the following? (Circle yes or no)

Cancer	Yes	No	Arthritis/Gout	Yes	No
Diabetes	Yes	No	Osteoporosis	Yes	No
High Blood Pressure	Yes	No	Thyroid Problems	Yes	No
Heart Disease	Yes	No	Fibromyalgia	Yes	No
Angina or Chest Pain	Yes	No	Polio	Yes	No
Shortness of Breath	Yes	No	Depression	Yes	No
Anemia	Yes	No	Kidney Disease	Yes	No
Pacemaker	Yes	No	Metal Implants	Yes	No
			Organ Transplants	Yes	No
Other (please explain)					

Please list any surgeries you have had, and the dates:

\_\_\_\_\_


For Women: Are you or could you be pregnant? \_\_\_\_\_

Are you taking prescription or over the counter medications (if yes, please list)

\_\_\_\_\_

Allergies: \_\_\_\_\_

Are you receiving home health care services? \_\_\_\_\_



Please rate your current pain on a scale of 0-10.  
0 represents **NO PAIN** and 10 represents **UNBEARABLE PAIN**.

<b>At Rest</b>	0	1	2	3	4	5	6	7	8	9	10
<b>With Activity</b>	0	1	2	3	4	5	6	7	8	9	10

Please list three activities you have difficulty performing because of your pain/symptoms:

1) \_\_\_\_\_  
2) \_\_\_\_\_