ADVANCED RELIEF INSTITUTE

Physical Therapy Intake Form

Name: _____ **Phone Number:** _____

OFFICE USE ONLY: BP: _____ **HR:** _____ **Height:** _____ **Weight:** _____

How long ago did your pain start? _____ Occupation: _____

Describe your symptom(s) and their location(s):

_____

_____

Rate your pain on a scale of 0-10 (0= No pain, 10= Excruciating) **Currently**: _____

Rate your pain on a scale of 0-10 (0= No pain, 10= Excruciating) **At its Best**: _____

Rate your pain on a scale of 0-10 (0= No pain, 10= Excruciating) **At its Worst**: _____

What makes your symptoms **worse**? _____

What makes your symptoms **better**? _____

Medical History:

YES	NO		YES	NO	
		Fever/Fatigue			Cardiac Problems/Pacemaker
		Nausea/Vomiting			Asthma/COPD
		Currently Pregnant			Seizures/Epilepsy
		High Blood Pressure			Hepatitis
		Diabetes			Osteoarthritis/Rheumatoid Arthritis
		Cancer			Fibromyalgia
		HIV/AIDs			OTHER:

Have you had any previous surgeries? If so, which surgeries?

_____

_____

Consent for Treatment:

I, _____, Date of Birth: _____, hereby give my consent to receive physical therapy, including initial assessments and treatments, provided by therapists under the supervision of the Advanced Relief Institute. I agree to the proposed treatment plan and understand that this consent covers the entirety of my current treatment and any future related conditions for which I may seek care.

Patient Signature: _____ Date: _____