A-TEAM
PHYSICAL THERAPY

MEDICAL INTAKE QUESTIONAIRE

Name: _____ Date: _____

Date of Surgery/Accident: _____ Age: _____ Ht. _____ Wt. _____

1.	History of Heart problems	YES / NO	details: _____
2.	Pace-Maker	YES / NO	details: _____
3.	High Blood Pressure	YES / NO	details: _____
4.	History of Cancer	YES / NO	details: _____
5.	Tumors or cysts removed	YES / NO	details: _____
6.	Tuberculosis	YES / NO	details: _____
7.	Skin Disorders	YES / NO	details: _____
8.	HIV Positive	YES / NO	details: _____
9.	Lung Disease	YES / NO	details: _____
10.	Asthma	YES / NO	details: _____
11.	Are You currently pregnant	YES / NO	details: _____
12.	Headaches	YES / NO	details: _____
13.	Dizziness	YES / NO	details: _____
14.	Blurred vision	YES / NO	details: _____
15.	Vomiting or Nausea	YES / NO	details: _____
16.	Numbness	YES / NO	details: _____
17.	Arthritis	YES / NO	details: _____
18.	Osteoporosis	YES / NO	details: _____
19.	Internal implants (metal or plastic)	YES / NO	details: _____
20.	Diabetes	YES / NO	details: _____
21.	Hepatitis A /B/C	YES / NO	details: _____
22.	Circulation problems	YES / NO	details: _____
23.	Are you a smoker?	YES / NO	details: _____

1. **Current Medications: _____**

2. **Where is your pain? _____**

3. **What is your goal for physical therapy? _____**

Circle a number you feel your pain is: (0 = no pain and 10 = emergency room pain)

Currently: 0 1 2 3 4 5 6 7 8 9 10

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