Andrew Physical Therapy
Intake Questionnaire

Name_____

Date of Injury:_____ **Date of Surgery**: _____

Please describe how injury occurred:

_____

_____

_____

Please list any medical conditions/surgeries:

_____

_____

_____

Please list any medications you are currently taking:

_____

_____

_____

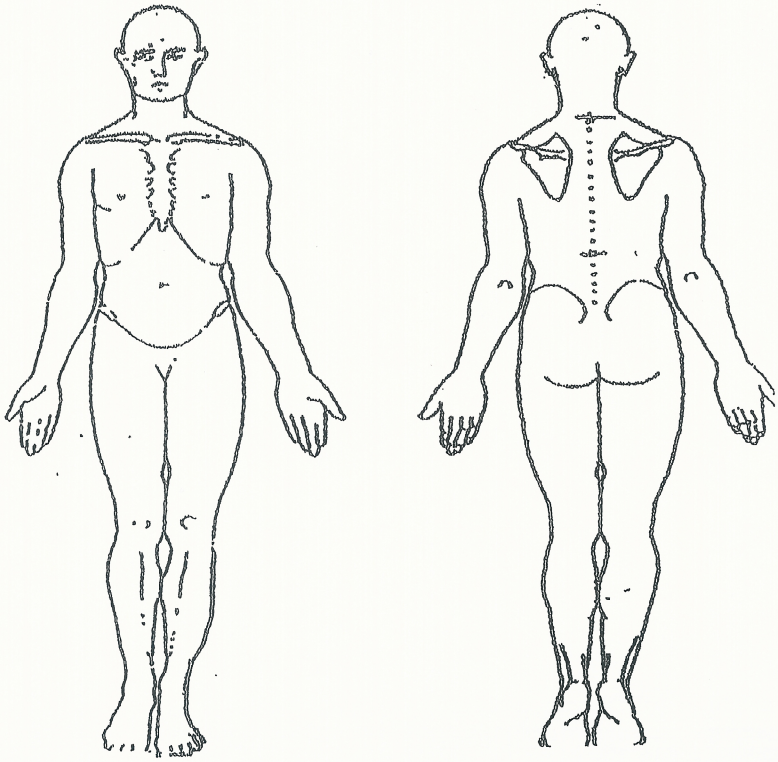
Have you had prior physical therapy: yes / no (circle one)

Where? _____ When?_____

What was your injury? _____

Pregnant female: NA Yes / No (circle one)

PLEASE MARK AREA OF DISCOMFORT ON BODY DIAGRAM BELOW:



Pain Scale--Please rate pain below:
(10 being a need to go to emergency room)

|----------|----------|
0 **5** **10**