

**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:

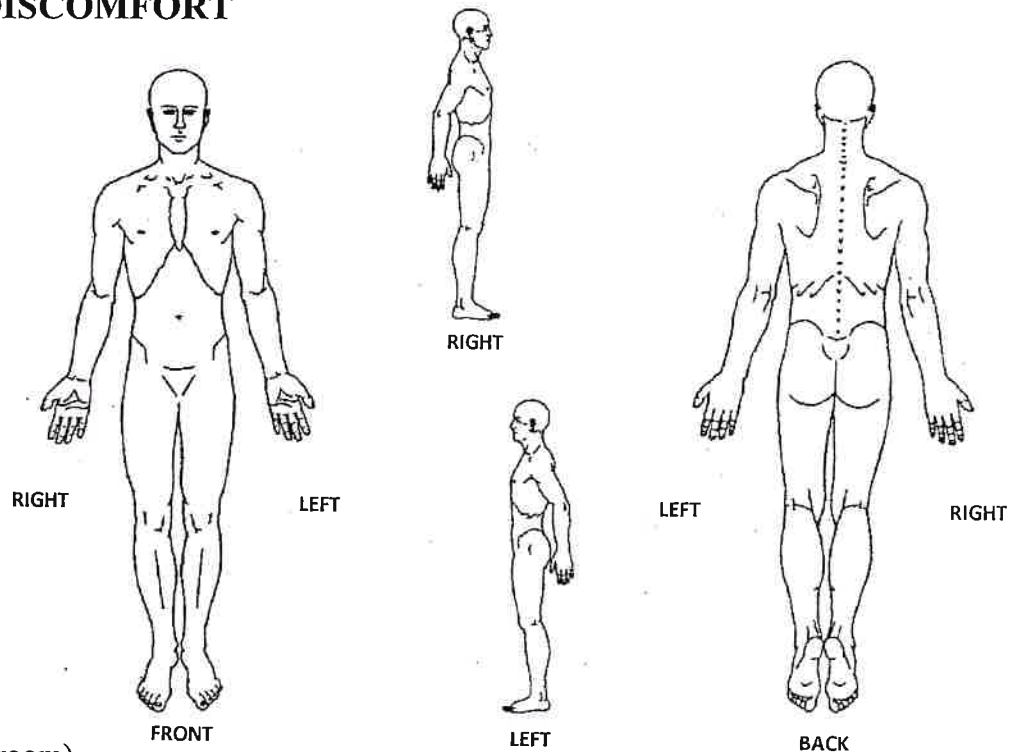
Have you had prior physical therapy: yes / no (circle one)

Where? _____ When? _____

What was your injury? _____

Pregnant female: NA Yes / No (circle one)

**PLEASE MARK AREA OF DISCOMFORT
ON BODY DIAGRAM:**



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

