Barnabas Health

Jersey City Medical Center
Department of Rehabilitation Services
Outpatient Physical Therapy
Medical History Intake Form

Patient label

Please take a few minutes to answer the following questions about your health and lifestyle to assist us in expediting your evaluation:

Date: ____/___/____ Patient's Name:_____

Physician:_____ Follow up appointment with physician: _____

Age: _____ Height: _____ Weight: _____

How do you learn best? _____ verbally _____ written _____ visually _____ demonstration

Reason for coming to Physical Therapy: _____

_____

_____

When did your symptoms begin? _____

Is this resulting from (circle one) : Accident Injury Recent Surgery Sudden Onset

Diagnostic Tests (circle all that apply): X-rays MRI CT-Scan Where?:_____

Do you have or have you ever had any of the following (check all that apply):

☐ Diabetes ☐ High Blood Pressure ☐ Heart Problems
☐ Heart Attack ☐ Lung/Respiratory Problems ☐ Cancer
☐ Osteoarthritis ☐ Rheumatoid Arthritis ☐ Asthma
☐ Bladder Dysfunction ☐ Allergries:_____
☐ Other: _____

Do you currently take any medication on a regular basis (please list)? _____
_____

Have you ever received physical therapy before (circle one): Yes No

If so, where? _____ When? _____

For what condition: _____ Result of therapy:_____

Living conditions (check all that apply):

☐ Apartment ☐ House ☐ Multiple Family Dwelling

☐ Flights of stairs:#_____ ☐ Railing on stairs: right side left side both sides

☐ Elevator ☐ Live Alone ☐ Live with family

☐ Live with others

Occupation: _____ Currently working? (circle one): Yes No

Please describe any pain using the following:

Location:_____

What makes your pain worse?: _____

What makes your pain better?: _____

What time of day is your pain the worst?: _____

Description (circle all that apply): Sharp Dull Ache Tingling Numbness Radiating

Rate your pain on a scale of 0-10 where 0 is no pain, 10 is the worst pain you have ever felt:

0 1 2 3 4 5 6 7 8 9 10 ☐ Constant ☐ Intermittent

Does this pain prevent you from sleeping or does it wake you up in the middle of the night?: Yes No

What activities do you feel that you cannot participate in because of this pain or condition? _____

_____

What are your goals an/or expectations for Physical Therapy? _____

_____

Please mark the following body diagrams with the markings as coded below:

_•_ pain

_x_ burning

_0_ tingling

_◊_ numbness

_=_ dull ache

_+_ other: _____