Parallel
Physical Therapy
& Wellness

Parallel Physical Therapy & Wellness

Patient Intake Form

Name: ______________________________ Date of Birth: ________________ Age: ________

Pronouns: ________________ Sex Assigned at Birth: ____________ Current Gender Identity: ____________

Address: __________________________ City: ________________ State: _____ Zip Code: ________

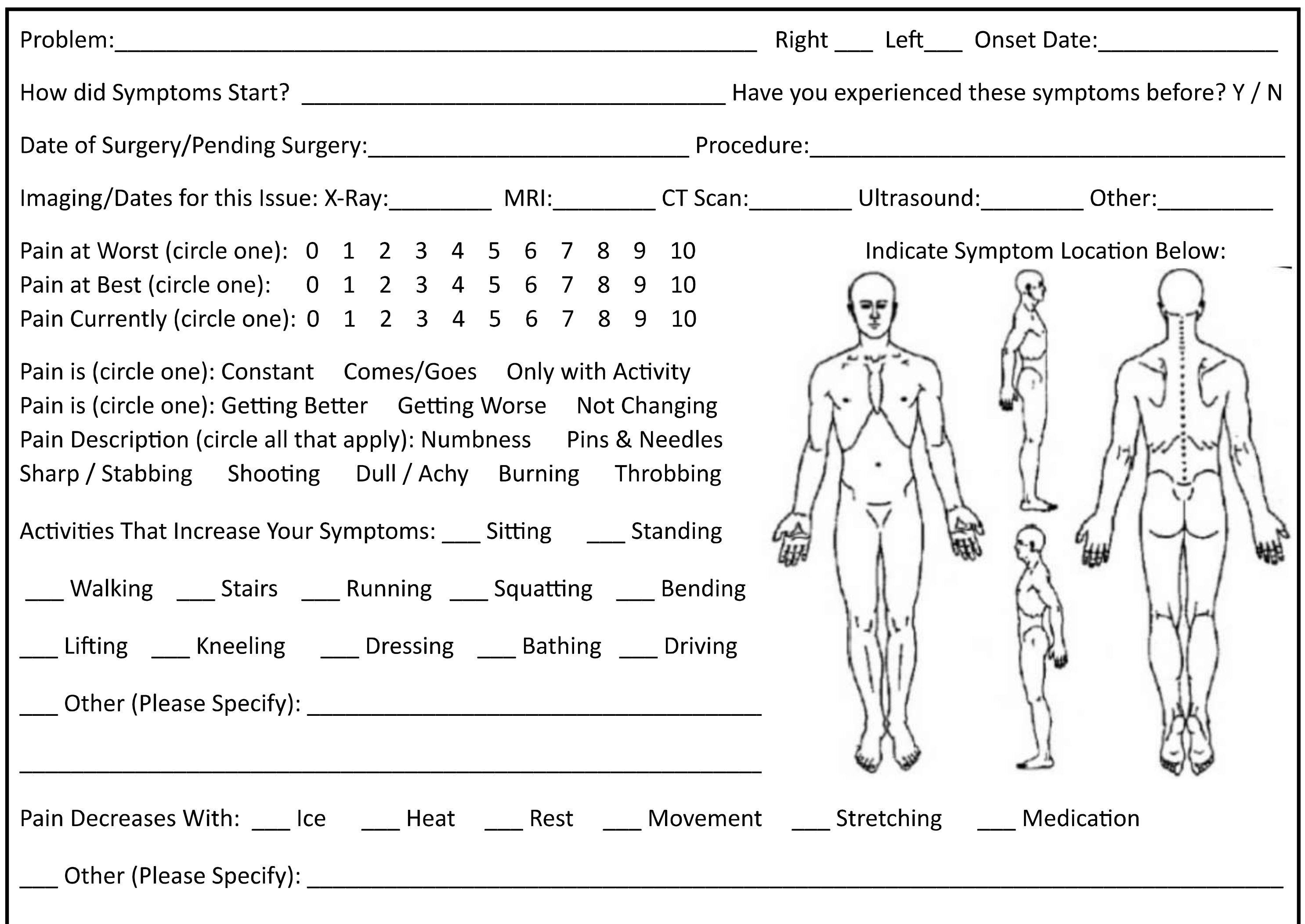
Home Phone: ________________ Cell Phone: ________________ E-mail: ________________________

Emergency Contact 1 Name: ____________________________ Relationship to you: ________________

Emergency Contact 1 Phone: __________________ E-mail: __________________________________

Emergency Contact 2 Name: ____________________________ Relationship to you: ________________

Emergency Contact 2 Phone: __________________ E-mail: __________________________________



Problem: ______________________________________ Right ___ Left___ Onset Date: ____________

How did Symptoms Start? ____________________________ Have you experienced these symptoms before? Y / N

Date of Surgery/Pending Surgery: ____________________ Procedure: ______________________________

Imaging/Dates for this Issue: X-Ray: ________ MRI: ________ CT Scan: ________ Ultrasound: ________ Other: ________

Pain at Worst (circle one): 0 1 2 3 4 5 6 7 8 9 10

Pain at Best (circle one): 0 1 2 3 4 5 6 7 8 9 10

Pain Currently (circle one): 0 1 2 3 4 5 6 7 8 9 10

Indicate Symptom Location Below:

Pain is (circle one): Constant Comes/Goes Only with Activity

Pain is (circle one): Getting Better Getting Worse Not Changing

Pain Description (circle all that apply): Numbness Pins & Needles

Sharp / Stabbing Shooting Dull / Achy Burning Throbbing

Activities That Increase Your Symptoms: ___ Sitting ___ Standing

___ Walking ___ Stairs ___ Running ___ Squatting ___ Bending

___ Lifting ___ Kneeling ___ Dressing ___ Bathing ___ Driving

___ Other (Please Specify): ______________________________

____

Pain Decreases With: ___ Ice ___ Heat ___ Rest ___ Movement ___ Stretching ___ Medication

___ Other (Please Specify): ____

Primary Care Physician: ____________________________ Phone Number: __________________

Referring Physician: _______________________________ Phone Number: ___________________

Job/Occupation: ______________________ Work Demands: ____

Exercise/Hobbies/Activities: ____

Current/Past PT/OT/Chiro/Massage? ____

Please circle any/all of the following problems you have or have had in the past:

Asthma/Breathing Problems	Alcohol/Drug Abuse	Arthritis	Alzheimer's or Dementia
Bowel/Bladder Problems	Bleeding Disorders/Blood Thinners	Chest Pain	Cancer
Cerebral Palsy	Circulatory Problems/Blood Clots	COPD/Emphysema	Diabetes
Depression or Anxiety	Dizziness/Fainting	Eating Disorders	Fractures (Broken Bones)
Headaches	Heart Attack/Heart Disease	Hernia	High Blood Pressure
High Cholesterol	Hepatitis	Infectious Disease	Irregular Periods
Kidney Problems	Liver/Gallbladder Problems	Multiple Sclerosis	Nausea/Vomiting
Osteoporosis or Osteopenia	Pregnancy (current or possible)	Parkinson's Disease	Pacemaker
Seizures/Epilepsy	Special Diet Guidelines	Skin Abnormalities	Sexual Dysfunction
Stomach Issues/GERD	Stroke	Tobacco Use	Urine Leakage

Other (Please Specify): ____

____

Allergies (Please List): ____

Please list any and all past surgeries (including dates): ____

____

____

____

Please list any and all Medications: ____

____

____

____

What is your goal for Physical Therapy? ____

Parallel
Physical Therapy
& Wellness

Parallel Physical Therapy & Wellness
Weekly Schedule

Occupation: ______________________ School/Work Name: ____

Other Exercise/Hobbies/Activities: ____

Please fill in the below chart with your typical weekly schedule. This will help us to better understand your daily routines. Items to include: Approximate wake and sleep times, school/work hours, other exercises/hobbies/activities and times spent doing these things daily.

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Wake Time: ______	Wake Time: ______	Wake Time: ______	Wake Time: ______	Wake Time: ______	Wake Time: ______	Wake Time: ______
Sleep Time: _______	Sleep Time: _______	Sleep Time: _______	Sleep Time: _______	Sleep Time: _______	Sleep Time: _______	Sleep Time: _______