EXCEL
PHYSICAL THERAPY & REHAB

3323 Shattuck Road, Suite # 2
Saginaw, MI 48603
Tel: (989) 341-1919
Fax: (989) 341-1920
www.excelptmi.com

Medical History and Intake Sheet

Please report your current complaints for which you are seeking the treatment: _____
_____

Please describe briefly how the current symptoms started: _____
_____
_____

Please describe your current functional limitations due to your medical condition:

- ☐ Sitting _____ mins.
- ☐ Stair Climbing
- ☐ Laundry
- ☐ Dressing/undressing
- ☐ Employment, please describe: _____
- ☐ Standing _____ mins.
- ☐ Sleeping _____ / night
- ☐ Vacuuming
- ☐ Yard Work
- ☐ Walking _____ mins.
- ☐ Lifting _____ pounds
- ☐ Driving _____ hours
- ☐ Other: _____

Please describe any other treatments sought till date: _____

Please describe any testing (X-ray, MRI) completed till date: _____

Are you allergic to latex: Yes / No

Follow up appt. with your physician: _____

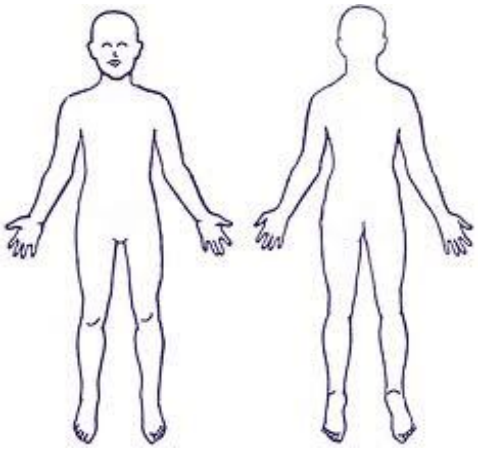
Dominant side: R / L

Prior Physical Therapy: Yes / No

If female, are you pregnant: Yes / No / May be

Do you smoke? Yes / No

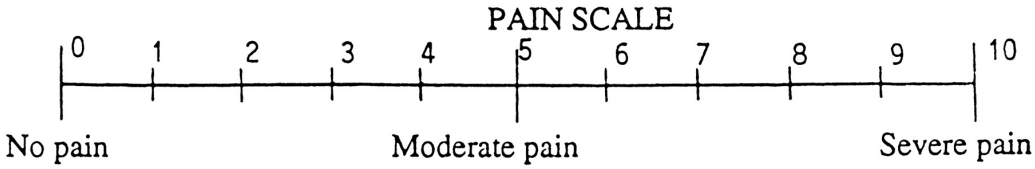
Body Diagram and Pain Scale



Instructions: On the body diagram shown on the side, mark the areas of pain or other symptoms according to symbol key below presently experiencing.

Symbol Key: Pain: →→→→ Numbness: =====
Tingling: ×××× Burning: ++++

Pain Scale Instructions: On the line below, please mark the intensity of pain presently experiencing.



Last Name: DOB:

First Name: Chart#:

EXCEL
PHYSICAL THERAPY & REHAB

3323 Shattuck Road, Suite # 2
Saginaw, MI 48603
Tel: (989) 341-1919
Fax: (989) 341-1920
www.excelptmi.com

Patient's Goal

Your goal from therapy: _____
_____

Medical History

Please check any medical condition for which you are being treated currently or in past.

- ☐ Diabetes Mellitus
- ☐ Arthritis
- ☐ Asthma
- ☐ Auto Accident
- ☐ Respiratory illness
- ☐ Head injury
- ☐ Carpal Tunnel
- ☐ Heart Problems
- ☐ Osteoporosis
- ☐ Stroke
- ☐ Blood clot/disorders
- ☐ Pacemaker
- ☐ Parkinson's disease
- ☐ Epilepsy/Seizures
- ☐ Multiple Sclerosis
- ☐ High Blood Pressure
- ☐ Cancer
- ☐ Gout
- ☐ Dizziness
- ☐ Broken bones/Fractures
- ☐ Other:

In the past year, have you experienced any of the following?

- ☐ Difficulty sleeping
- ☐ Loss of appetite
- ☐ Depression
- ☐ Loss of balance
- ☐ Unexplained changes in weight
- ☐ Vision/hearing changes
- ☐ Unexplained weakness
- ☐ Bladder/bowel problems
- ☐ Difficulty breathing/chest pain

Please list all current medications including those over the counter: _____
_____
_____

Surgical History

Please list any surgeries and an approximate year of Surgery	**Year**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Last Name: DOB:

First Name: Chart#: