TEAM IOWA | PHYSICAL THERAPY

Patient Medical History & Intake

Name_____

Issue to be Assessed Today (location(s) and description): _____

_____

_____

Start date of symptoms/date of surgery: _____

How did your problem begin?: _____

_____

What makes your symptoms better? _____

What makes your symptoms worse? _____

Have you received physical or occupational therapy this calendar year? Y N
If yes, how many visits? _____

What is your goal for therapy? _____

Previous medical history: list past surgeries w/ dates and any other important medical info:

_____

_____

Medications currently taking (if applicable): _____

_____

_____

Is there anything else we should know that is pertinent to your treatment?

_____

_____