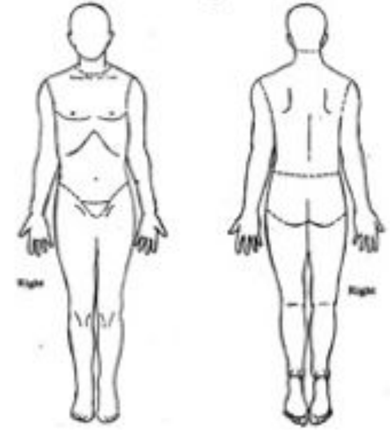
Currents

Physical Therapy + Wellness

26607 Carmel Center Place, Suite 203 | Carmel, CA 93923 | (831) 238-0677 | kelseynakata@currentspt.com | currentspt.com

Medical Intake Form



Patient Name: ____

Age: __________

Area(s) of symptoms (Please indicate on BODY CHART):

____

____

____

Date of Onset / Injury:

____

Mechanism of Injury:

____

____

Severity of symptoms:

0 1 2 3 4 5 6 7 8 9 10 (Worst)

Description of symptoms (Circle all that apply):

Sharp Dull Ache Numbness Tingling

Other: ____

Frequency of symptoms:

0% 25% of day 50% of day 75% of day Constant

Other Treatment?

____

Goals -- What activities would you like to return to?

____

____

Past Medical History (Have you had a similar injury to this body region before? If so, when?):

____