WHYoga
PHYSICAL THERAPY

Client Intake Form

Personal Information (Please print clearly)

Name: Last: _____ First: _____ MI: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Telephone: H: (_____) _____ C: (_____) _____ W: (_____) _____ Date of Birth: _____

Sex: ☐ M ☐ F Marital Status: ☐ S ☐ M ☐ W ☐ D Email: _____

Emergency Contact: _____ Phone: (_____) _____ Relationship: _____

Medical Information

Reason for Referral: _____

In general, your pain level is:

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 *(Check one: 1 = low, 10 = high)*

Referring Physician: _____ Phone: (_____) _____

Primary Physician: _____ Phone: (_____) _____

Present Condition

- **What is the primary complaint that brings you into treatment today:**
- **Secondary complaint:**
- **As a result, I am now having difficulty with:** _____
- **When and how did symptoms begin?** _____**Date:** _____

Previous Treatments for this Condition:

Treatment Type	Yes / No	How Long?	Helpful? (Yes/No)
Physical Therapy	☐ Yes ☐ No	_____	☐ Yes ☐ No
Myofascial Release	☐ Yes ☐ No	_____	☐ Yes ☐ No
Chiropractic	☐ Yes ☐ No	_____	☐ Yes ☐ No
Acupuncture	☐ Yes ☐ No	_____	☐ Yes ☐ No
Other: _____	☐ Yes ☐ No	_____	☐ Yes ☐ No

Past Medical History

Surgeries: _____

Accidents: _____

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Current Medications

(List ALL, including supplements/herbal/homeopathic remedies. Include reason for each.)

_____

_____

_____

Symptom Checklist

(Mark with M = Monthly, W = Weekly, D = Daily)

Circulatory / Respiratory

☐ Headaches/migraines _____
☐ Dizziness _____
☐ Shortness of breath _____
☐ Chest pain/tightness _____
☐ Heart disease _____
☐ Varicose veins _____
☐ Fainting _____
☐ Cold feet/hands _____
☐ Lymphedema _____
☐ Excessive sweating _____
☐ High/Low blood pressure _____
☐ Diabetes _____

Musculoskeletal

☐ Joint stiffness _____
☐ Joint swelling _____
☐ Spasms/cramps _____
☐ Fractured bones _____
☐ Strains/sprains _____
☐ Back/hip pain _____
☐ Neck/shoulder pain _____
☐ Arm/hand pain _____
☐ Leg/foot pain _____
☐ Jaw pain/TMJ _____
☐ Tendonitis _____
☐ Bursitis _____
☐ Scoliosis _____
☐ Arthritis _____
☐ Osteoporosis _____

Digestive / Urinary

☐ Indigestion _____
☐ Constipation _____
☐ Diarrhea _____
☐ Bowel irregularity _____
☐ Liver disease _____
☐ Bloating/gas _____
☐ Heartburn _____
☐ Stomach cramps _____
☐ Nausea/vomiting _____
☐ Painful urination _____
☐ Frequent urination _____
☐ Urgent urination _____
☐ Incomplete urination _____
☐ Unable to hold urine _____
☐ Kidney disease _____
☐ Ulcers _____

Nervous System

☐ Numbness/tingling _____
☐ Twitching of face _____
☐ Fatigue _____
☐ Daytime tiredness _____
☐ Extreme fatigue _____
☐ Chronic pain _____
☐ Sleep disorders _____
☐ Epilepsy/seizures _____
☐ Stroke _____
☐ Paralysis _____
☐ Sweaty palms _____
☐ Blood clots _____
☐ Allergies _____
☐ Sinus condition _____
☐ Asthma _____

Reproductive

☐ Currently pregnant _____
☐ Previous pregnancies _____
☐ Live births _____
☐ Premature births _____
☐ Irregular periods _____
☐ Painful periods _____
☐ PMS _____
☐ Endometriosis _____
☐ Menopause _____
☐ Hot flashes _____
☐ Breast lump/tenderness _____
☐ Hysterectomy _____
☐ Prostate condition _____
☐ Impotence _____

Miscellaneous

☐ Loss of appetite _____
☐ Coughing _____
☐ Congestion _____
☐ Vertigo/earache _____
☐ Sore throat _____

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☐ Forgetfulness _____
☐ Confusion _____
☐ Hearing impaired _____
☐ Difficulty concentrating _____
☐ Visually impaired _____
☐ Eyestrain _____
☐ Blurry vision _____
☐ Eye irritation _____
☐ Eating disorder _____
☐ Herpes/shingles _____
☐ Cerebral palsy _____
☐ Chronic fatigue syndrome _____
☐ Multiple sclerosis _____
☐ Muscular dystrophy _____
☐ Parkinson's disease _____
☐ Spinal cord injury _____
☐ Fibromyalgia _____
☐ Cancer _____
☐ Infectious disease _____
☐ Rashes _____
☐ Athlete's foot _____

☐ Metal implants _____
☐ Alcohol use _____
☐ Nicotine use _____
☐ Caffeine use _____
☐ Uninterested in sex _____
☐ Unable to enjoy sex _____
☐ Water retention _____

Psychological

☐ Unable to cope _____
☐ Easily annoyed/irritated _____
☐ Depression _____
☐ Anxiety _____
☐ Difficulty with family _____
☐ Difficulty with friends _____
☐ Worrisome thoughts _____
☐ Recurring bad thoughts _____
☐ Thoughts of suicide _____
☐ Fearful of people/place _____

Sleep, Exercise, Lifestyle

Do you have trouble falling asleep? ☐ Yes ☐ No
Is your sleep restful? ☐ Yes ☐ No
How many times do you wake in the night? _____
How long before you fall back asleep? _____
Do you engage in regular exercise? ☐ Yes ☐ No
Type/How often: _____
Are you able to exercise now? ☐ Yes ☐ No
Do you have discomfort, shortness of breath, or pain with exercise? ☐ Yes ☐ No
In general, your lifestyle is: ☐ Active ☐ Average ☐ Inactive

Patient Goals

List activities you would like to be able to do as a result of therapy:

1. _____
2. _____
3. _____

Other goals: _____

Activity: _____ **Duration/Frequency:** _____ **By When:** _____

Consent

I have stated all medical conditions to the best of my knowledge and will update the therapist of any changes in my health status.

Client's Signature: _____ **Date:** _____