Biosports
PHYSICAL THERAPY

Name_____ **PATIENT INTAKE FORM**

What is your primary complaint or concern?

_____

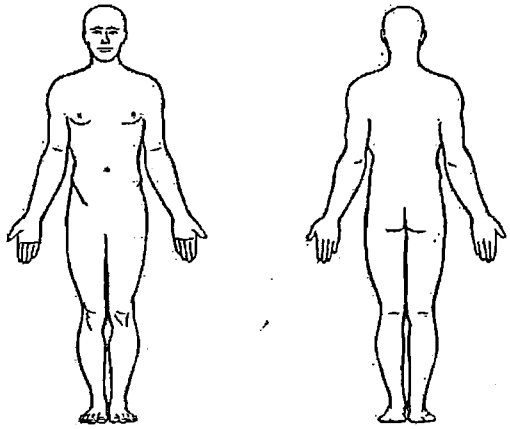
When did this start?

_____

How did this start?

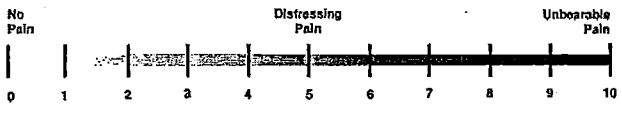
_____

Please draw your symptoms and describe your symptoms, and indicate whether they are intermittent or constant

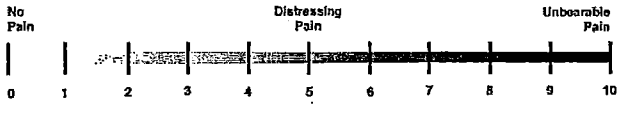


If you have pain, please rate your pain level

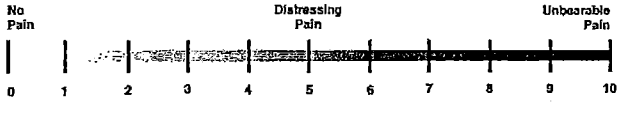
Current pain level



The best your pain has been in the last week



The worst your pain has been the last week



509 ▪ 665 ▪ 3156 FAX 509 ▪ 665 ▪ 0414
18 N. WORTHEN • SUITE 200 • WENATCHEE • WASHINGTON 98801 • WWW.BIOSPORTS.NET

PLEASE COMPLETE THE OTHER SIDE

When are your symptoms worst?

❑ Morning ❑ Afternoon ❑ Evening ❑ Night ❑ After exercise/work ❑ N/A

When are your symptoms the best?

❑ Morning ❑ Afternoon ❑ Evening ❑ Night ❑ After exercise ❑ N/A

What makes your symptoms worse?

What makes your symptoms better?

What other treatments have you tried to address these symptoms, and were they helpful?

Have you had anything similar or related before?

Do you have any other significant, related medical history, i.e surgeries, health issues etc?

What diagnostic tests or imaging have been performed for this problem/concern?

What are your normal activities of daily living?

Of these normal activities, is there anything you are unable to do now because of your problem/concern?

Are you getting ❑ Better ❑ Worse ❑ Staying the same?

What are your goals in coming to Biosports?

When do you see your physician next?
