

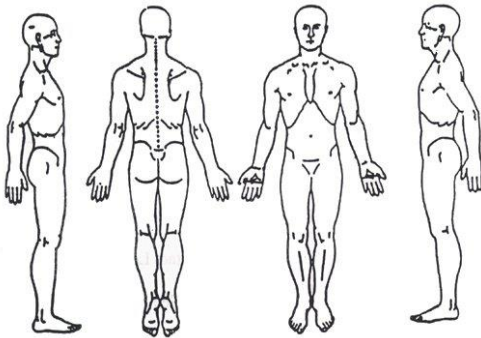


## DREAM PHYSICAL THERAPY INTAKE FORM

1. Briefly describe your problem:
2. When did your problem begin?
3. What activities are affected by your problem (Ex. Tennis, Squash, Running, Etc.)?
4. What makes your problem better?
5. What makes your problem worse?
6. Are you seeing anyone else for this problem?

**PAIN DIAGRAM:** On the diagram below, please describe in the comments where you are currently experiencing pain or other symptom's (numbness, tingling, etc.)

**ADDITIONAL COMMENTS BELOW:**



**MEDICAL / SURGICAL HISTORY:** Please list any information that is relative to your receiving physical therapy:

**MEDICATIONS:** Please list ANY medications you are currently taking:

**PATIENT SIGNATURE:**

**DATE:**