AVANT
PHYSICAL THERAPY

PATIENT INTAKE HISTORY

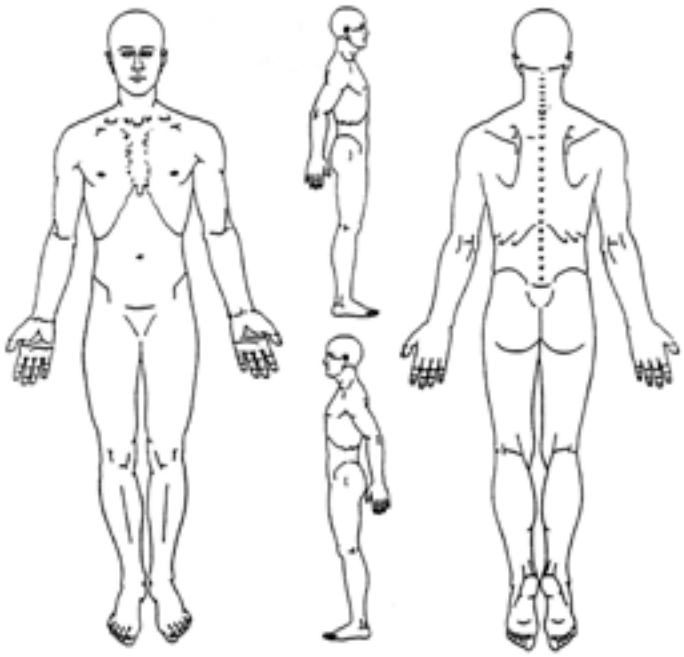
Name..... Weight..... Height..... Age.....

CURRENT INJURY *(Check all that boxes that apply)*

Affected body part..... Date of onset/injury: .....

- ☐ Surgery, type ..... Date.....
- ☐ Muscular weakness
- ☐ Headaches
- ☐ Night pain
- ☐ Unexplained weight change of over 10 pounds in 3 months
- ☐ Dizziness or vertigo
- ☐ Bowel or bladder changes
- ☐ Numbness or tingling
- ☐ Fever/sweats
- ☐ Chills
- ☐ Nausea/vomiting

Please draw the location of your symptoms:



Please tell us more about your pain:

	NONE 1	2	3	4	MODERATE 5	6	7	8	9	WORST 10
AT WORST	○	○	○	○	○	○	○	○	○	○
AT BEST	○	○	○	○	○	○	○	○	○	○
CURRENT	○	○	○	○	○	○	○	○	○	○

PREVIOUS MEDICAL HISTORY *(Check all that boxes that apply)*

Do you have a history of the following:

- ☐ Shortness of Breath
- ☐ Allergies
- ☐ Asthma
- ☐ Eating Disorders
- ☐ Incontinence or urinary leakage
- ☐ Urinary retnetion or difficulty toileting
- ☐ Blood in urine or stool
- ☐ Stress fractures or reactions: If yes, how many? .....
- ☐ Blood clots
- ☐ Gender affirming surgery
- ☐ Depression
- ☐ Anxiety
- ☐ Bipolar disorder
- ☐ PTSD
- ☐ Chemical dependency
- ☐ Multiple sclerosis
- ☐ Osteoperosis or osteopenia
- ☐ Headaches
- ☐ Dizziness

Have you or any immediate members of your family been diagnosed with the following:

- ☐ Cancer
- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Heart Disease
- ☐ Chest Pain
- ☐ Stroke
- ☐ Arthritis