PATIENT INTAKE FORM

Last Name: ________________________________ First Name ________________________________

Street Address: ____ Apartment #: ____________

City: ____ State: ________ Zip Code: ______________

Date of Birth: ________/_______/___________ Gender (circle one) : M F Neutral Trans

SSN:_____________ - __________ - _____________ Marital Status (circle one): S M D W

Email Address: ____

Phone: (Home) ____________________________ (Cell) ___________________________________

Are you currently working? Y N **(**circle one**)**

Employer/Company:______________________________ Occupation: _________________________

Employer's Address/Ph.#____

Is Your Injury/Pain Work or Auto Related? Yes No Date of Accident___________________

Name of your Health Insurance? ___________________ Member ID#: _________________________

Emergency Contact Name:_____________________________ Telephone #.:_________________________

Relationship to the patient____

How did you hear about our office?

___ Referred by a Physician. Name of the Physician ____

___ Referred by a former patient (please list their name so we can thank them!):___________________

___ Found online Or ___ Through Insurance company

___ Other (please specify): ____

If patient is under 18, please complete the following:

Parent/Guardian Name:____

Relationship to Patient: _________________________ Date of Birth: __________________________

Patient's or Guardian's Signature: _____________________________ Date: _______________________

PATIENT QUESTIONNAIRE

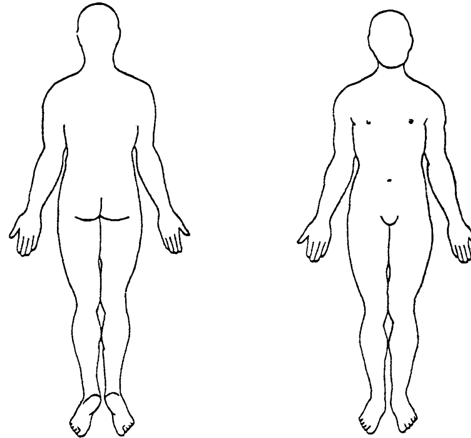
Last Name_________________________ First Name ___________________________DOB__________

What problem/issue brings you in today? ____

____

Body Chart:

Please mark the areas where you feel pain/symptoms on the chart to the right with the following symbols:



X - Pain
||| - Numbness
= - Tingling

Is your pain: __Sharp __Dull __Shooting __Aching __Deep __Tingling __ Burning __Stabbing

When and how did your present symptoms start? ____

____

What makes your symptoms **worse**? ____

What **relieves** your symptoms?____

Are your symptoms worse in the : ____ Morning ____ Afternoon ____ Evening ____ Inconsistent

Have you received Physical Therapy this calendar year? _________ How many sessions? __________

What diagnostic tests (X-ray, MRI, CT scan, EMG) have you had for this problem in the past?________
_____________________________________When and Where?___________________________________

____

MEDICARE PATIENTS ONLY: Are you currently receiving Home Health Care? Yes No (circle)
If yes, provide the name of agency and dates of treatment____

WOMEN ONLY: Are you currently pregnant or think you might be pregnant? Yes No

PATIENT MEDICAL HISTORY

Last Name________________________ First Name __________________________DOB__________

- Please, circle the following:

Do you smoke? Yes No If yes, how many cigarettes a day?__________	Do you consume alcohol? Yes No If yes, how many drinks per week? ___________
Do you have pacemaker? Yes No	Are you Latex sensitive? Yes No

- **Have you recently experienced any of the following (check all that apply)?**

___ Changes in bowel/bladder function
___ Shortness of breath
___ Nausea/vomiting
___ Weakness/fatigue
___ Loss of control of urine
___ Headaches
___ Dizziness/lightheadedness
___ Difficulty maintaining balance while walking
___ Difficulty swallowing
___ Unintended weight loss/gain
___ Numbness/tingling
___ Fever/chills/sweats
___ Pain at night
___ Changes in appetite
___ Pain caused by cough or sneeze
___ Frequent falls

- **Other medical history (check all that apply):**

___ Diabetes
___ Cancer
___ High blood pressure
___ Asthma
___ Cardiovascular conditions
___ Rheumatoid arthritis
___ Osteoarthritis
___ Osteoporosis
___ Motor vehicle accidents
___ Fractures
___ HIV
___ Neurological conditions
___ Chronic aches/pain
___ Stroke/TIA
___ Other

- During the past month, have you experienced feelings of depression or hopelessness? Yes No

Past Surgeries:
Past Hospitalizations:
Allergies:
Medications:

I certify, that the above information is correct. I authorize this clinic to bill my insurance company directly for the covered portion of charges, and I authorize payment of benefits directly to this clinic. I authorize this clinic to release medical or other information necessary to process this claim. I understand, that I am ultimately responsible for medical charges, and I agree to pay my deductible, my co-insurance or co-payment, and any charges not reimbursed by my insurance carrier. I understand, that some insurance companies require medical or administrative pre-authorization for treatment, or have reimbursement limits on physical therapy treatments. I understand, I am responsible for knowing and meeting the requirements of my insurance plan.

Signature: ____ Date:____________________________