Physical Therapy Intake Form

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1. Please enter your information.

Name: _____ Date of Birth: _____

Street Address: _____ Apt./Unit #: _____ City: _____ State: _____ Zip Code: _____

Gender:
○ Male ○ Female

Social Security #: _____

Home Phone: _____ Mobile Phone: _____ Email Address: _____ Add to eNewsletter List? _____

Employer: _____ Work Phone: _____

Preferred mode of communication:
○ Home Phone ○ Mobile Phone ○ Work Phone
○ Email Address

May we leave a message?
○ Yes ○ No

2. Preferred Language:

○ English ○ Spanish
○ Other

If other, specify: _____

3. Race (Please check all that apply):

☐ White ☐ Black ☐ Asian
☐ American Indian/Native Alaskan ☐ Native Hawaiian/Pacific Islander ☐ Other

If other, specify _____

4. Ethnicity:

☐ Hispanic/Latino(a)

5. How did you learn about this office? _____ Who referred you? _____

6. Emergency Contact:

Name: _____ Relationship: _____

Telephone #: _____ Alt. Phone: _____

Signing this form confirms my authorization to disclose protected health information for medical purpose.

7. Check below the protected health information you (the patient) authorize to be disclosed:

- ○ All medical information
- ○ None
- ○ Only the following

If only the following, please specify:

_____

8. Authorization will end:

- ○ Until revoked
- ○ Deceased
- ○ Specified date

If specified date, specify:

_____

9. Referring Physician: _____ Phone: _____

10. Do you have Medical Insurance?

- ○ Yes
- ○ No

11. Primary Insurance

Primary Insurance Company _____ Member ID / Policy # _____ Group Number _____

Client Relationship to Insured

○ Self ○ Spouse ○ Child ○ Other

Insured Name _____ Insured Phone # _____ Insured Date of Birth _____ Insured Gender ○ Female ○ Male

Insured Street Address _____ Insured City _____ Insured State _____ Zip Code _____

Do you have secondary insurance?

○ Yes ○ No

12. Secondary Insurance

Secondary Insurance Company | Member ID / Policy # | Group Number

Client Relationship to Insured
○ Self ○ Spouse ○ Child ○ Other

Insured Name | Insured Phone # | Insured Date of Birth | Insured Gender ○ Female ○ Male

Insured Street Address | Insured City | Insured State | Zip Code

13. Workers' Compensation Carrier: | Claim #:

14. Is your insurance through your job?

- ○ Yes
- ○ No

I authorize the release of any medical information necessary to process my claim and payment of benefits.

Signature | Date

15. What concern brings you in today?

16. Inciting injury or trauma?

- ○ Yes
- ○ No

17. Date of Onset/Injury:

18. If yes, describe:

19. Is your injury:

- ○ Auto related
- ○ Accident Related
- ○ Work Related

20. Have you had surgery for this condition?

- ○ Yes
- ○ No

If yes, date of surgery?

_____

21. If yes, please describe surgery:

_____

22. Does anything make your symptoms better?

_____

Does anything make your symptoms worse?

_____

23. Are your symptoms:

- ○ Improved
- ○ Worse
- ○ Stable

24. Please indicate if you have any of these concerns:

- ☐ Pain
- ☐ Decreased Mobility
- ☐ Swelling/Edema
- ☐ Stiffness
- ☐ Loss of function

25. If you have pain, is it:

- ☐ Sharp?
- ☐ Dull?
- ☐ Shooting?
- ☐ Burning?
- ☐ Stabbing?
- ☐ Tingling?
- ☐ Intermittent?
- ☐ Constant?
- ☐ Deep?
- ☐ Superficial?
- ☐ Other

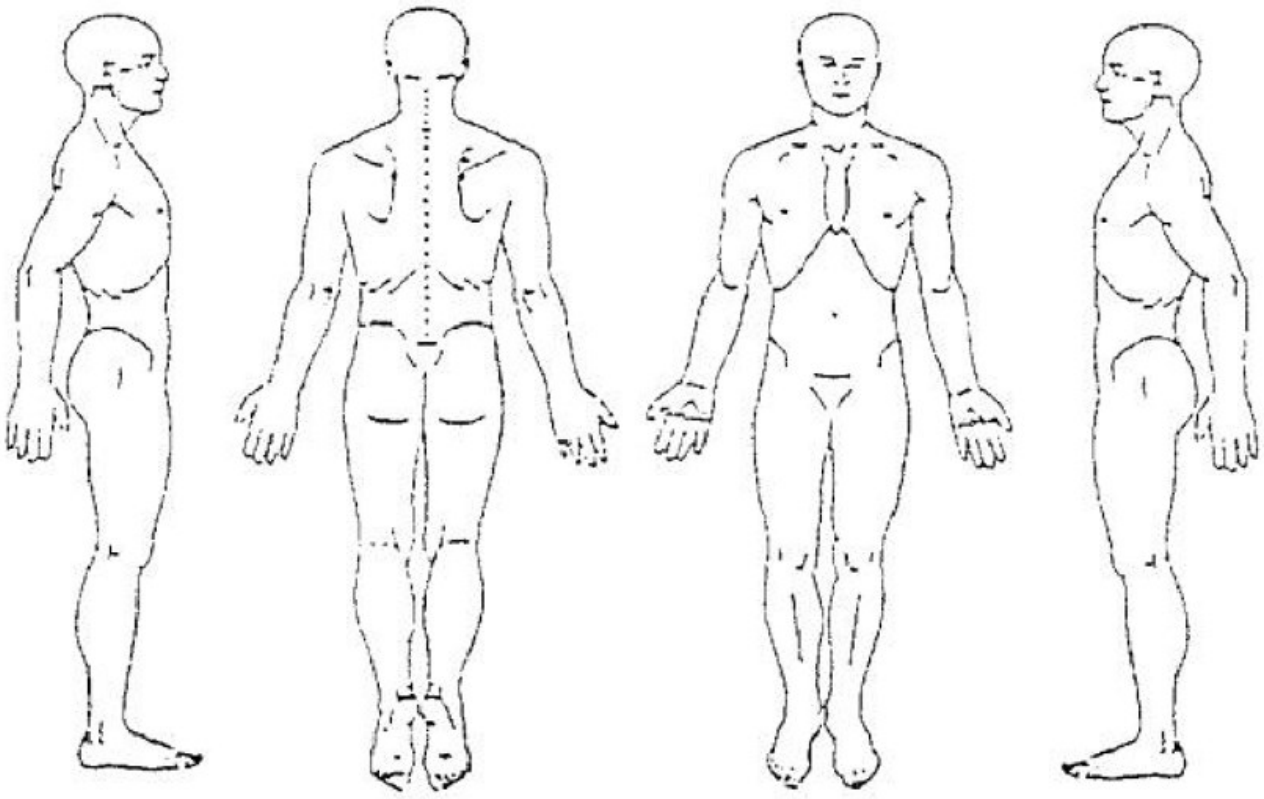
If other, specify:

_____

26. How severe is your pain: 0= no pain, 10= excruciating pain?

- ○ 0
- ○ 1
- ○ 2
- ○ 3
- ○ 4
- ○ 5
- ○ 6
- ○ 7
- ○ 8
- ○ 9
- ○ 10

27. Indicate on the chart below the location(s) of the problem:



28. Is this problem affecting your daily life?

- Yes
- No

29. If yes, please explain:

_____

30. Have you undergone any special tests for this condition?

- Yes
- No

31.
- MRI
- CT Scan
- X-ray
- EMG
- Other

If other, specify:

_____

32. If yes, please explain and include diagnosis:

_____

33. Have you been treated for this problem before?

- Yes
- No

34. If yes, have you been treated with:

- Physical Therapy
- Chiropractor
- Pilates
- Medication
- Other
- Massage
- Exercise
- Trigger Point Injection
- Surgery

If other, specify:

_____

35. Did this help?

- Yes
- No

36. Explain:

_____

37. Are you receiving home health services?

- Yes
- No

38. If yes, name of agency:

_____

If yes, please list services:

_____

39. What goal(s) do you have for your physical therapy sessions?

_____

Medical and Health History

40. How would you rate your physical health?

- Excellent
- Fair
- Good
- Poor

41. Height - ft.: _____ Height - in.: _____ Weight (lbs.): _____

42. Please answer the following questions:

	Yes	No
Do your symptoms interrupt your sleep?		
Do you experience dizziness/lightheadedness?		
Have you had any falls over the past year?		
Do you have problems with coordination?		
Do you have blurred vision or other vision changes?		
Do you have a hearing impairment?		
Have you had a sudden change in bladder/bowel habits?		
Have you had a recent change in weight or appetite?		
Do you have any heat or cold intolerance?		
Do you have nausea/vomiting?		
Do you have bruising or bleeding problems?		
Do you use assist devices for mobility (i.e walker, orthotics, cane)?		
Do you have shortness of breath or decrease in exercise tolerance?		
Do you have osteoporosis/osteopenia?		
Do you have any implanted devices?		
Do you have a history of seizures?		
Do you have recurrent headaches?		
Do you have high blood pressure?		
Do you have any heart problems?		
Do you have diabetes?		
Are you (or could you be) pregnant?		

43.

	Medical Conditions/injury
1	
2	
3	

44. Past surgeries?

- ○ Yes
- ○ No

45. If yes, please list:

46. Do you smoke?

- Yes
- No
- Past

47. Packs/Day: Years:

48. Drink alcohol?

- Yes
- No
- Past

49. Drinks/Day: Years:

50. Drink caffeine?

- Yes
- No
- Past

If yes, how many cups/day?

51. Use pain medications?

- Yes
- No
- Past

If yes, what medication?

52. Use recreational drugs?

- Yes
- No
- Past

If yes, what drug/s?

53. Are you employed?

- Yes
- No

54. Occupation:

_____

55. Are there any physical demands of your job?

- Yes
- No

56. If yes, please explain:

_____

_____

_____

_____

57. Activity level:

- Sedentary
- Moderate
- Extremely Active
- Light
- Active

58. If active, indicate the type and duration of exercise/sports:

_____

_____

_____

_____

Family History

59. Does anyone in your family (parent or sibling) have a history of:

	Yes	No
Diabetes		
High Blood Pressure		
Heart Problems		
Cancer		

Client Signature	Date