PATIENT INFORMATION

Name: ______________________ Date of Birth: __________

Address: ______________________

City: ______________________ State: ______ Zip: __________

Home #: __________ Work # : __________ Cell #: __________

Email: ______________________ Physician: __________

Emergency contact: ______________________ Phone: __________

Is your injury work related? YES / NO If **YES**, please fill in below:

Employer Name: ______________________

Employer Address: ______________________ City: __________

State: ______ Zip: __________ Contact: __________

RESPONSIBLE PARTY INFORMATION

Relationship to insured (circle one): SELF SPOUSE PARENT OTHER:

Name (if different than above): ______________________ DOB: __________

City: ______________________ State: ______ Zip: __________

H #: __________ W #: __________ C #: __________

Were you ever treated for outpatient physical therapy before? ☐ Yes ☐ No

Has a doctor prescribed physical therapy for your current condition? ☐ Yes ☐ No

If YES: Physician's Name: ______________________ Phone: __________

If NO: Primary Care Physician's Name: ______________________ Phone: __________

Who may we thank for your referral? Doctor / Friend / Former Patient / Other: __________

MEDICAL INTAKE QUESTIONAIRE

Patient Name: ______________________________ Date: ______________

Medical History *(check all that apply)*:

☐ Alzheimer's
☐ Anxiety Disorders
☐ Autoimmune Disease
☐ Cardiovascular Disease
☐ Cardiac Arrhythmia
☐ Currently Pregnant
☐ Diabetes Mellitus Type 1 / 2
☐ Depression
☐ Dizziness
☐ Fibromyalgia
☐ Fracture/Suspected Fracture
☐ High Blood Pressure
☐ Hepatitis A/B/C
☐ History of Cancer
☐ HIV or Immunosuppression
☐ Lyme Disease
☐ Neurologic Disease
☐ Osteoarthritis
☐ Osteoporosis/penia
☐ Pacemaker
☐ Parkinson's
☐ Rheumatoid Arthritis
☐ Stroke
☐ Traumatic Brain Injury
☐ Other (please specify): ______________________________

Are you currently ill? ☐ Yes ☐ No If YES, please describe: ______________________________

____

Current Occupation: ______________________________

Current Daily Activity/Activities: ______________________________

Patient Goals for Physical Therapy: ______________________________

Current Medications and/or Supplements:

Medication / Supplement	Dosage	Frequency	Route of Administration

History of Current Condition

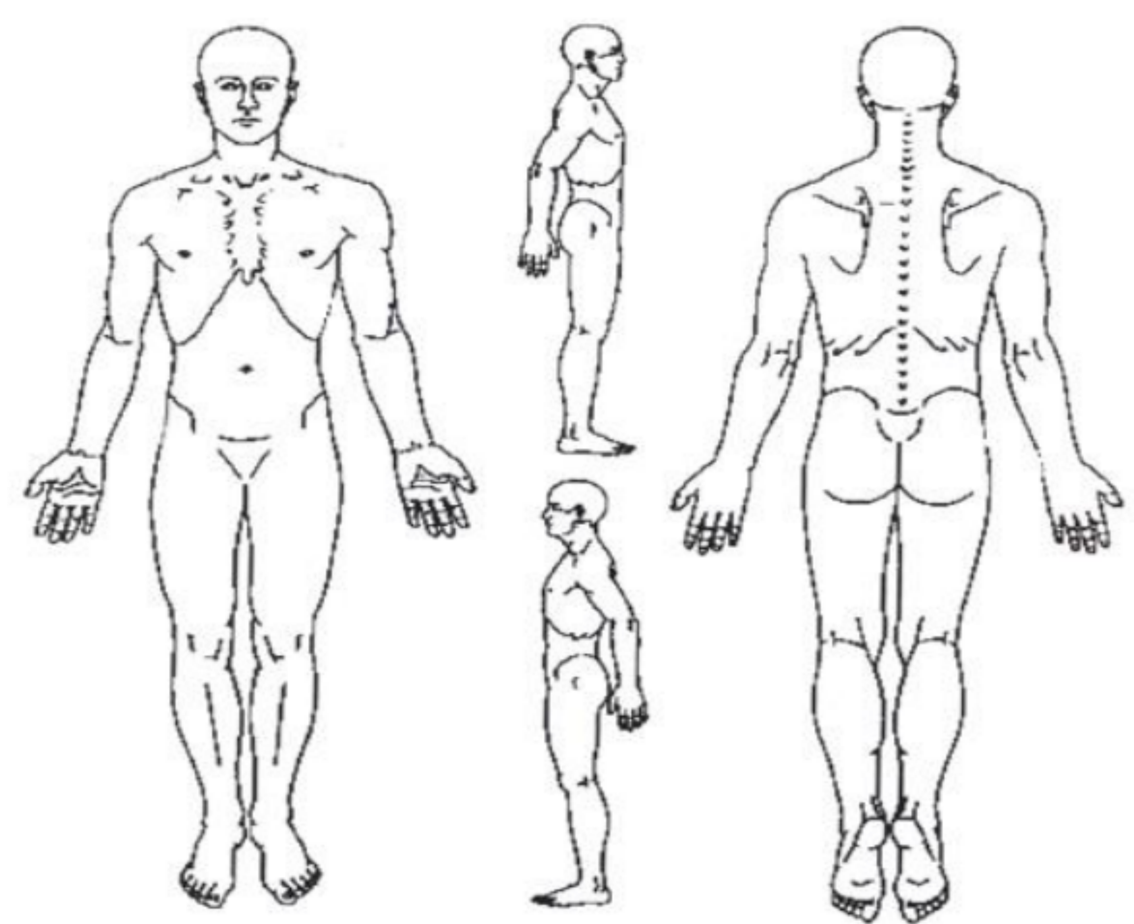
Date of Injury or Accident: ______________________________

Date of Surgery (if applicable): ______________________________

Please **rate your pain** on a scale of 1 – 10 (0 = no pain, 10 = emergency room pain)

At Worst: ______ / 10
Average: ______ / 10
At Best: ______ / 10

Please mark **location** of your pain and/or symptoms:



Please **describe** your symptoms *(circle all that apply)*:

Dull / Achy / Sharp / Throbbing / Stabbing / Shooting / Numbness / Tingling / Burning

Other: ______________________________