PATIENT INTAKE FORM:

NAME: _____ DATE OF BIRTH (DOB): _____ GENDER: M □ F □
STREET ADDRESS: _____ CITY:_____
STATE: _____ ZIP: _____ PHONE Home (____) _____ PHONE Cell (____)_____

EMAIL ADDRESS: _____

EMERGENCY CONTACT: _____ EMERGENCY PHONE: (____)_____
INSURANCE: _____MEMBER NAME:_____ MEMBER DATE OF BIRTH:_____

PHYSICIAN:_____ FACILITY: _____ PHYSICIAN PHONE: (____)_____

HOW DID YOU HEAR ABOUT US? _____

CHIEF COMPLAINT /BODY PART TO BE TREATED: _____

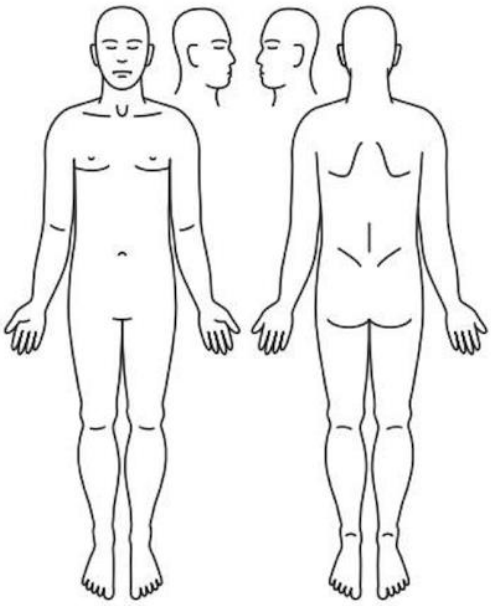
HAVE YOU RECEIVED THERAPY/HOME HEALTH FROM A DIFFERENT PROVIDER WITHIN THE LAST 6 MONTHS?

YES □ NO □ IF YES, FACILITY: _____

WE PROVIDE COURTESY APPOINTMENT REMINDERS. DO YOU PREFER: PHONE CALL □ TEXT □ EMAIL □

1. How would you rate your overall health? Good □ Fair □ Poor □

2. Indicate on the drawings to the right where you have pain/symptoms.



3. How would you describe the type of pain?

□ Sharp □Shooting
□ Dull □Stiff
□ Achy □Numb
□ Burning □Other:_____

4. How are your symptoms changing over time?

o Getting worse o Staying the same o Getting better

5. How would you rate your pain/problem? (0 being no pain/problem).

At Worst: 0 1 2 3 4 5 6 7 8 9 10

Current: 0 1 2 3 4 5 6 7 8 9 10

At Best: 0 1 2 3 4 5 6 7 8 9 10

6. Are you pregnant? NO □ YES □ Due date: _____

7. List relevant surgical procedures and dates: _____
_____

8. Surgical precautions or restrictions (if applicable): _____

9. Have you had any falls in the last 6 months? NO □ YES □ : If Yes, How many? _____

10. Check the box if you have any of the following:

Amputation/Prosthesis		Glaucoma/Cataracts		Parkinson's Disease	
Anemia		Gout		Polio	
Angina/Chest Pain		Guillian Barre Syndrome		PTSD	
Arthritis		Headaches		Psychiatric Care	
Asthma		Heart Attack		Rheumatic Fever	
Cancer: Type : _____ Mets: Y/N		Heart Disease		Seizures	
Chemotherapy/Radiation: Lymph node removal: Y/N		Herniated Disc		Stroke/CVA/TIA	
COPD		High/Low Blood Pressure		Traumatic Brain Injury	
Diabetes/Insulin		Kidney Problems		Tuberculosis	
Drug/Alcohol Abuse		Multiple Sclerosis		Tumors/Growths	
Emphysema		Osteoporosis		Wounds/ Ulcers	
Epilepsy		Pacemaker		Other: _____	

11. Who else have you seen for your problem?

□ Chiropractor □ Physical Therapist □ Primary Care Physician
□ Neurologist □ ER Physician □ Orthopedist
□ Other: _____

12. How long have you had this problem, and how did it begin? _____

13. What aggravates your problem? _____

14. What concerns you the most about your problem and what does it prevent you from doing?
_____

15. List all prescriptions and over-the-counter medications you are currently taking:
_____

16. What is your goal for physical therapy: _____

I UNDERSTAND THE ABOVE INFORMATION AND GUARANTEE THIS FORM WAS COMPLETED CORRECTLY TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANGES TO MY MEDICAL STATUS.

Signature of Patient_____ Date: _____