Patient Intake Form

Patient's Name: ____ Date: _________________________

Mailing Address ____

City: _____________________________State: ________________Zip Code: _____________________________

Home Phone ___________________ Work phone _____________________ Cell Phone ______________________

Contact Preference: □ Home □ Work □ Cell □ E-mail E-mail Address_____________________________________

SSN ___________________________ Birth Date __________________ Sex: □ Female □ Male

Marital Status: □ Single □ Married □ Divorced □ Widowed Spouse/Partner's Name _________________________

Employer: ____

Primary Physician ______________________________ Referring Physician ______________________________

Emergency Contact ___________________________________ Relationship _________________________________

Emergency Contact Phone # ____

INSURANCE INFORMATION: PLEASE GIVE YOUR CARDS TO THE FRONT DESK FOR SCANNING

Primary Insurance ____

If Medicare: Have you had any Physical or Speech therapy this calendar year: YES NO

Subscriber's Name ____ Birthdate ______________________

ID Number ______________________________________ Group number _______________________________

Secondary Insurance ____

Subscriber's Name ____ Birthdate ______________________

ID Number ____________________________________ Group number _________________________________

IF YOU HAD AN ACCIDENT PLEASE COMPLETE THIS SECTION

Date of accident ___________How did it happen? □ Auto □ Work □ Other State in which injury occurred ________

Claim number ___________________Insurance company (worker's comp or auto PIP) ______________________

Address _______________________________Claims Adjuster __________________ Phone # _____________

-» I verify that the above information is accurate (Signature) ____

Please tell us how you learned of our service and whom we can thank:

□ I was a **Former Patient** □ **Former Patient** recommendation □ Found us on the **Internet**

□ **Family/Friend/Co-worker** recommendation □ **Doctor** recommendation □ **Radio** advertisement

□ **Phone book** □ **Publication/Newspaper**; what Publication: ______________________

□ **Clinic Sign** □ Saw you at an **event**: what Event: _________________________

Dynamic Physical Therapy

Patient Questionnaire/Health History

Patient Name: ____ **Date:** ________________________________

To ensure your receive a complete and thorough evaluation, please provide us with the important background information on the following form. If you do not understand the question, your therapist will assist you. Thank you!

History of Present Condition:

What are your current symptoms? ____________________________

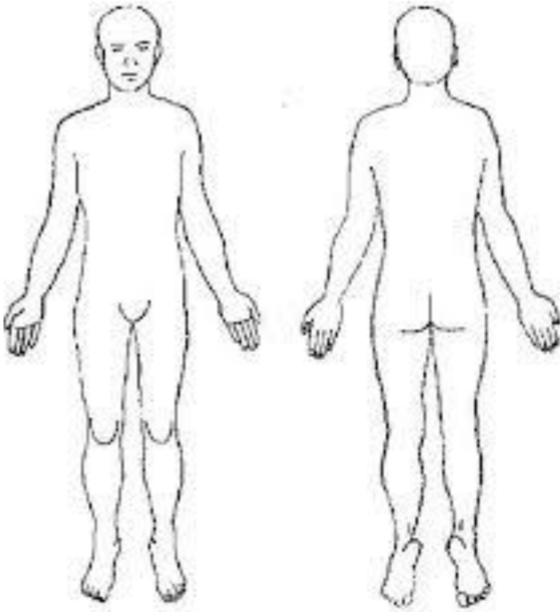
____

____

____

____

Please indicate the area of **pain** or **abnormal** sensation on the body chart below (shade in the appropriate area)



When did your symptoms begin? ____________________

Was onset gradual or sudden : □ Gradual □ Sudden

Since onset are symptoms getting:
□ better □ worse □ not changing

Have you had similar symptoms in the past? YES NO

Have you had more than one episode? YES NO

Which of the following **best describes** how your injury occurred? (If your condition is post-surgical please indicate as per original injury)

□ Lifting
□ MVA (car accident)
□ A fall
□ Overuse (cumulative trauma)
□ During recreation/sports
□ Trauma
□ Blow to the face
□ Throwing
□ An incident at work
□ Degenerative process
□ Unknown
□ Other

Nature of pain/symptoms (check all that apply)

□ sharp □ aching □ constant
□ dull □ periodic □ other ______________
□ throbbing □ occasional ____________________

Throughout the day do your symptoms: (check one)

□ increase □ decrease □ stay the same

Does the pain wake you at night? YES NO

Since onset of your current symptoms have you had:

□ any difficulty with control of bowel or bladder function
□ fever/chills
□ any numbness in the genital or anal area
□ numbness in arms or legs
□ any dizziness or fainting attacks
□ weakness
□ unexplained weight change
□ night pain/sweats
□ malaise (vague feeling of bodily discomfort)
□ problems with vision/hearing
□ none of these

What **aggravates** your symptoms? (check all that apply)

- □ sitting
- □ going to/rising from sitting
- □ lying down
- □ walking
- □ up/down stairs
- □ reaching overhead
- □ reaching in front of body
- □ reaching behind back
- □ reaching across body
- □ talking, chewing, yawning
- □ recreational sports including
- □ repetitive activities
- □ household activities
- □ standing
- □ squatting
- □ sleeping
- □ coughing/sneezing
- □ taking a deep breath
- □ looking up overhead
- □ swallowing
- □ stress
- □ sustained bending
- □ other: ______________________________________

What **relieves** your symptoms? (check all that apply)

- □ sitting
- □ heat
- □ cold
- □ stretching
- □ wearing a splint/orthosis
- □ rest
- □ standing
- □ walking
- □ exercise
- □ lying down
- □ massage
- □ medication
- □ nothing
- □ other ______________ ___________________

Have you had any previous treatment for this condition?

____

Have you had any imaging done? (x-rays, MRI, CT scan)

____

Medication

Please list any prescription medications you are currently taking (pain pills, injections and/or skin patches, etc):

____
____
____
____
____

General Health

How would you rate your general health?

□ Excellent □ Good □ Average □ Poor

Do you exercise outside of normal daily activity?

- □ 5+ days/wk
- □ 3-4 days/wk
- □ 1-2 days/wk
- □ occasionally
- □ none

Exercise, Sports/Recreation consists of: _____________
____
____
____

Past Medical History

Have you ever been diagnosed with any of the following conditions? (check all that apply)

- □ Cancer (type) ____________
- □ Depression
- □ Stroke
- □ Kidney problems
- □ Thyroid problems
- □ Diabetes
- □ Multiple Sclerosis
- □ Head injury
- □ Stomach problems
- □ Parkinson’s disease
- □ Infectious diseases
- □ Arthritis
- □ Heart problems
- □ High blood pressure
- □ Lung problems
- □ Blood disorders
- □ Epilepsy/seizures
- □ Allergies
- □ Rheumatoid arthritis
- □ Osteoporosis
- □ Broken bones
- □ Circulation/vascular problems
- □ Other _____________

Do you smoke? If yes, how much? __________________
____

Are you currently pregnant? ________________________

Work History

Occupation: _____________________________________

Physical Activities at work (check all that apply)

- □ sitting
- □ standing
- □ phone use
- □ repetitive lifting
- □ heavy lifting
- □ computer use
- □ heavy equipment operation
- □ driving
- □ other __________________

Are you currently receiving or seeking disability for this condition?

YES NO

If not performing your normal activities at work do you plan to RETURN to your previous activity level?

YES NO