POTENTIAL
THERAPY SERVICES

Patient Intake / Medical History

Name:_____ Sex: M F DOB:_____ Height:_____ Weight:_____

Address: _____

Cell Phone: _____ Home Phone:_____ Email:_____

Emergency Contact:_____Phone:_____

Relationship to patient:_____ Referring Physician:_____

Is this treatment covered by any other payer other than your personal insurance? Yes No

If yes, then who? Worker's Compensation Motor Vehicle Insurance Other: _____

If you are a Medicare patient, have you been involved in a Home Health Episode? Yes No

How did you hear about us? _____

What is your reason for attending therapy: _____

Date of Injury/Onset:_____ Cause of injury:_____

Please rate your pain on a scale 0-10 (0 = no pain,1-2 mild discomfort, 3 tolerable, 4 distressing, 5-6 alters current activities, 7 very intense, need assistance for ADLs, disabled, 8-9 excruciating, childbirth, 10 unspeakable pain, losing consciousness, medical emergency)											
Lowest pain in the last week	(please circle one)	0	1	2	3	4	5	6	7	8	9	10
Worst pain in the last week	(please circle one)	0	1	2	3	4	5	6	7	8	9	10
Current pain, at this very moment	(please circle one)	0	1	2	3	4	5	6	7	8	9	10

Do you use tobacco? ❑No ❑Yes **Allergies:** ❑Latex ❑Lotions ❑ Adhesives ❑Other:_____
Are you currently pregnant? ❑No ❑Yes **Do you have a pacemaker?** ❑No ❑Yes **Metal implants?** ❑No ❑Yes

Do you know have or have you ever had any of the following conditions? (Circle all that apply)

Anemia	Depression	Respiratory Problems	Heart Problems –what?_____	
Arthritis		Diabetes	Cancer –where?_____	
High Blood Pressure		Kidney problems	Back/neck surgery-explain_____	
Fractures		Headaches	Thyroid problems	Dizziness
Joint Replacement		Nerve injury	Fibromyalgia	Seizures
GI problems				
Parkinson's		Stroke/TIA	Multiple Sclerosis	COPD
Asthma				

Please list your medications or provide a list for us to copy.

Medication	Dosage	Frequence (times/day)	Route of Administration

I agree that the above information accurately describes my medical history and that should any changes in my medical history occur, I will notify my physical therapist immediately

Signature:_____Date:_____