Patient Intake Form

Today's Date: _____

Demographic Information

Full Legal Name: _____ Preferred Name: _____
Date of Birth: _____ Gender: _____ SSN: _____
Mailing Address: _____
Physical Address: _____
Email Address: _____
Mobile Phone: _____ Home Phone: _____
How do you want to be notified of your upcoming appointments? ☐ Text ☐ Email
PCP Name: _____ Phone: _____

Reason for Being Seen

Are you seeking treatment due to a motor vehicle accident or worker's compensation claim? ☐ Yes ☐ No
What are we seeing you for today? _____

MVA or Worker's Compensation Claim Information ☐ *Not applicable*

Insurance Carrier Name: _____
Claim #: _____ Date of accident/injury: _____
Adjuster Name: _____ Adjuster Phone: _____
Attorney Name: _____ Attorney Phone: _____

Primary Health Insurance Information ☐ *Not applicable Self-Pay*

Insurance Carrier Name: _____
Insurance ID #: _____ Group #: _____
Subscriber Name: _____ Date of Birth: _____
Patient relationship to the subscriber: _____
Subscriber Address: _____

Secondary Health Insurance Information ☐ *Not applicable*

Insurance Carrier Name: _____
Insurance ID #: _____ Group #: _____
Subscriber Name: _____ Date of Birth: _____
Patient relationship to the subscriber: _____
Subscriber Address: _____

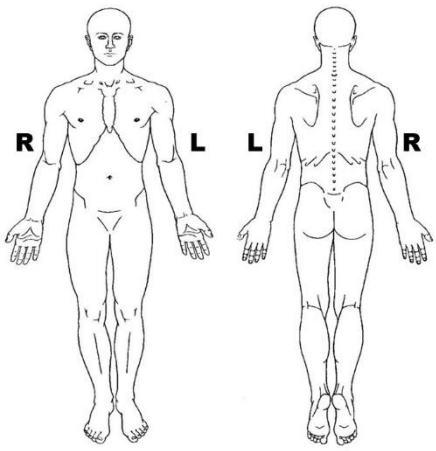
Emergency Contact

Name: _____ Relationship: _____
Phone: _____
May we share information regarding your care with your emergency contact? ☐ Yes ☐ No

Additionally

How did you hear about us? _____
Are you interested in strength training after you complete your physical therapy? ☐ Yes ☐ No
Are you interested in our fitness or performance services? ☐ Yes ☐ No

Medical History Section



On the body chart above, please indicate what area(s) you are being seen for today.

1. Please indicate the side of your issue:
   ☐ Right ☐ Left ☐ Both sides ☐ Not applicable
2. Rate your pain: *("0" no pain up to "10" worst pain ever)*
   Current (0-10) _____ Best (0-10) _____ Worst (0-10) _____
3. Describe your symptoms:

☐ Achiness	☐ Intermittent	☐ Shooting
☐ Burning	☐ Numb	☐ Stabbing
☐ Deep	☐ Piercing	☐ Superficial
☐ Dull	☐ Sharp	☐ Tingling

4. What makes your symptoms worse? _____
5. What makes your symptoms better? _____
6. Are your symptoms worse in the:
   ☐ Morning ☐ Afternoon ☐ Evening ☐ Inconsistent
7. Are your symptoms: ☐ Improving ☐ Worse ☐ Stable

8. What is your chief complaint? _____
9. How has this issue affected your daily life/routine? _____
10. When and how did your issue begin? _____
11. Have you experienced this issue before? ☐ Yes ☐ No
12. Are you seeing (or have you been seen by) any other healthcare provider for your current issue? ☐ Yes ☐ No
    If so, who? _____
13. As a result of your current issue, have you had any of the following: ☐ X-ray ☐ CT Scan ☐ MRI ☐ Other: _____
14. Tell us about your prior medical history including surgeries: _____
15. Please list any allergies you may have: _____
16. Does any of your immediate family have a history of diabetes, high blood pressure, cardiac issues, or cancer? ☐ Yes ☐ No
    If yes, please explain: _____
17. Have you had surgery as a result of your issue? ☐ Yes ☐ No
18. Please list any medications you are currently taking: