Patient Intake & Medical History

Patient's Name: ____ Date: ______________

Address: ________________________________ City ______________ Zip ______________

Phone: (Home) ________________ (Cell) ________________ Gender: M F Marital Status: S M D W

Patient's Date of Birth: ________________ Email: ____________________________________

Employer: ____________________________ Contact: ______________ Phone: __________

Emergency Contact: ______________________ Phone: ______________________________

Name of Insurance Card Holder: ______________________ Date of Birth: ______________

Circle Who Is To Be Billed: Self Work Comp Legal/Accident Insurance Other

Past Medical History: ____

Have you been diagnosed with: Diabetes Heart condition Pacemaker Cancer______________

Referring Physician: __________________________Date of follow up visit with Doctor: _________

Diagnosis: ____________________________________Date of Injury: ______________

How did the injury occur? ____

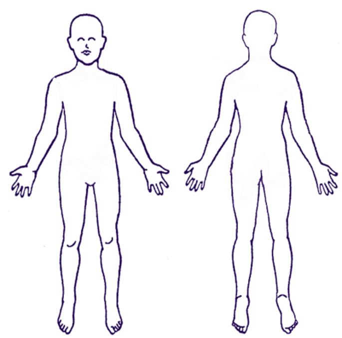
Diagnostic Testing: ❒ X-Rays ❒ MRI ❒ CT ❒ EMG ❒ Other:______________________

Surgery: ____ Date of Surgery: ______________

Medications for current condition: ____

Previous PT/OT Treatment: ___________________________ Where: ________________

Current Pain Level: (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Pain)



Pain Location: ____

When did your pain begin? ______________________________________

What makes your pain better? ____________________________________

What makes your pain worse? ____________________________________

Work Status: Full Duty Restricted Off Duty Hrs per week: _____ Restrictions? ____________