Telehealth Intake Form

Patient Name: _____ DOB: _____ Age:_____
Street Address: _____ City, state, Zip: _____
Phone: _____

Emergency Contact Name: _____Relationship to Patient:_____ Phone: _____

PATIENT INFORMATION

Occupation: _____

Hobbies / Leisure Activities: _____

Exercise Routine: _____

What can I help you with? _____

When did these problems start? _____ Is it getting: Better __ Worse __ Same__

Have you had similar problems in the past? _____

You know yourself better than anyone. In your own words, what do you think is going on?
_____

Providers you have you seen for your symptoms:_____

Tests/imaging you had done for this issue (list with dates):
_____

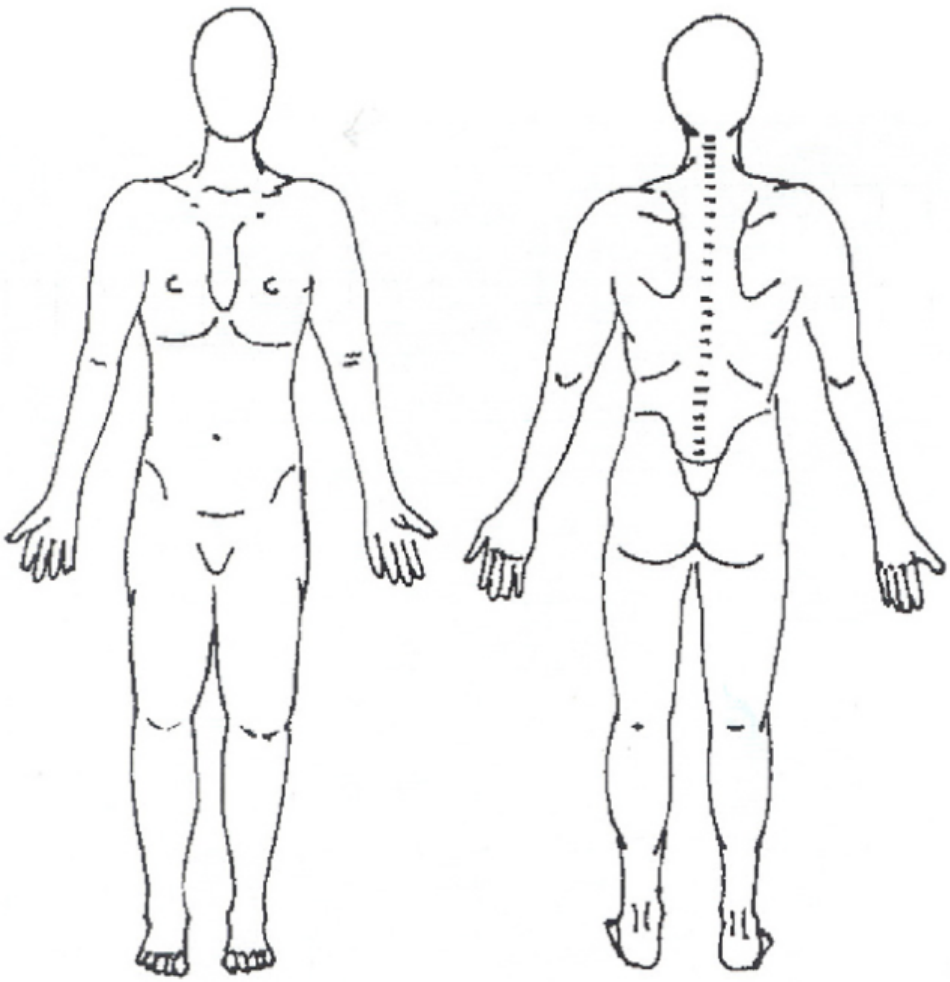
What are your goals for our telehealth sessions? (E.g. "when I'm done I will be able to…")
_____
Surgeries (list with dates)
_____

List any medications (prescribed and over the counter), vitamins, and supplements you are currently taking:

Pain Diagram and Pain Rating

Please use the diagram below to indicate the symptoms you have experienced over the past 24 hours. **Be VERY precise when drawing the location of your pain.** Use the key to indicate the type of symptoms.

Key: Pins and Needles = 000000 Stabbing = //////
Burning = xxxxxx Deep Ache = zzzzzz



Please rate your current level of pain on the following scale (check one):

0 1 2 3 4 5 6 7 8 9 10
(no pain) (worst imaginable pain)

Please rate your worst level of pain in the last 24 hours on the following scale (check one):

0 1 2 3 4 5 6 7 8 9 10
(no pain) (worst imaginable pain)

Please rate your best level of pain in the last 24 hours on the following scale (check one):

0 1 2 3 4 5 6 7 8 9 10
(no pain) (worst imaginable pain)

Circle YES or NO…

In the past 3 months have you had or do you experience:

A change in your health ?	Yes….. No
Nausea/Vomiting ?	Yes….. No
Fever/chills/sweats ?	Yes….. No
Unexplained weight change ?	Yes….. No
Numbness or tingling ?	Yes….. No
Changes in appetite ?	Yes….. No
Shortness of breath ?	Yes….. No
Dizziness ?	Yes….. No
Upper respiratory infection ?	Yes….. No
Urinary tract infection ?	Yes….. No
Difficulty swallowing ?	Yes….. No
Changes in bowel or bladder function ?	Yes….. No

Have you or any immediate family member ever been told you have:

	Self	**Family**
Cancer ?	Yes….. No	Yes….. No
Connective Tissue Disorder?	Yes….. No	Yes….. No
Diabetes ?	Yes….. No	Yes….. No
High blood pressure ?	Yes….. No	Yes….. No
Heart disease ?	Yes….. No	Yes….. No
Angina/chest pain ?	Yes….. No	Yes….. No
Stroke ?	Yes….. No	Yes….. No
Osteoporosis ?	Yes….. No	Yes….. No
Osteoarthritis ?	Yes….. No	Yes….. No
Rheumatoid arthritis ?	Yes….. No	Yes….. No

Do you have a history of:

Alcoholism ?	Yes….. No
Allergies/Asthma ?	Yes….. No
Bone Marrow or Solid Organ Transplant ?	Yes….. No
Headaches ?	Yes….. No
HIV/AIDS?	Yes….. No
Kidney disease ?	Yes….. No
Rheumatic fever ?	Yes….. No
Ulcers ?	Yes….. No
Sexually transmitted disease ?	Yes….. No
Seizures ?	Yes….. No

Are you currently:

Pregnant ?	Yes….. No
Depressed ?	Yes….. No
Under Stress ?	Yes….. No
Taking high dose corticosteroids ?	Yes….. No

Please check any boxes that apply to you:

- ☐ Anemia
- ☐ Anxiety
- ☐ Breathing problems
- ☐ Cardiac Pacemaker
- ☐ Chemical Dependency
- ☐ Childbirth
  - ☐ # of vaginal births: _____
  - ☐ # of C-sections: _____
- ☐ Circulation Problems
- ☐ Constipation
- ☐ Depression
- ☐ Diabetes
- ☐ Disrupted Sleep

If yes, please explain:

_____

- ☐ Dizzy Spells
- ☐ Dental/Jaw/TMJ Problems
  - ☐ clenching
  - ☐ grinding
  - ☐ jaw pain/TMJD
  - ☐ Missing teeth
  - ☐ other
- ☐ Dysautonomia (Pott's Disease or other)
- ☐ Emphysema/Bronchitis
- ☐ Fibromyalgia
- ☐ Fractures, Location: _____
- ☐ Gallbladder Problems
- ☐ Hepatitis
- ☐ Hearing problems
- ☐ Kidney Problems
- ☐ Metal Implants
- ☐ Neurologic Disorder, Type: _____
- ☐ Pelvic floor concerns
  - ☐ Pelvic pain
  - ☐ Trouble holding back gas
  - ☐ Urinary frequency/hesitancy/urgency
  - ☐ Urinary leakage
  - ☐ Constant dribbling of urine
  - ☐ Fecal incontinence
  - ☐ other
- ☐ Speech problems
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Trauma (physical, childhood, emotional)
- ☐ Vision Problems
- ☐ Whiplash
- ☐ Head trauma/TBI/concussion

Please specify any other medical conditions/concerns not listed above, if any:

Medically Informed Consent

I voluntarily consent to services deemed necessary by Derya Anderson. I acknowledge that no guarantees have been made to me as to the results of these services provided by Dr. Anderson. I understand that this is not a physical therapy assessment, treatment, or follow up, but rather a wellness visit for general health and well being. I understand that this is not a service that is billable to insurance or medicare, but rather it is cash pay only.

I (_____) have read this form and fully understand and accept its terms and conditions.

_____ _____

Signature of patient Date

Cancellation Policy

Patients who do not arrive for a scheduled appointment or do not provide 24- hours notice to change an appointment will be charged a **cancellation fee equal to the full amount of their missed appointment**. This charge will be billed to your card on file.

_____ _____

Signature of patient Date