Essential Physical Therapy 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):
_____

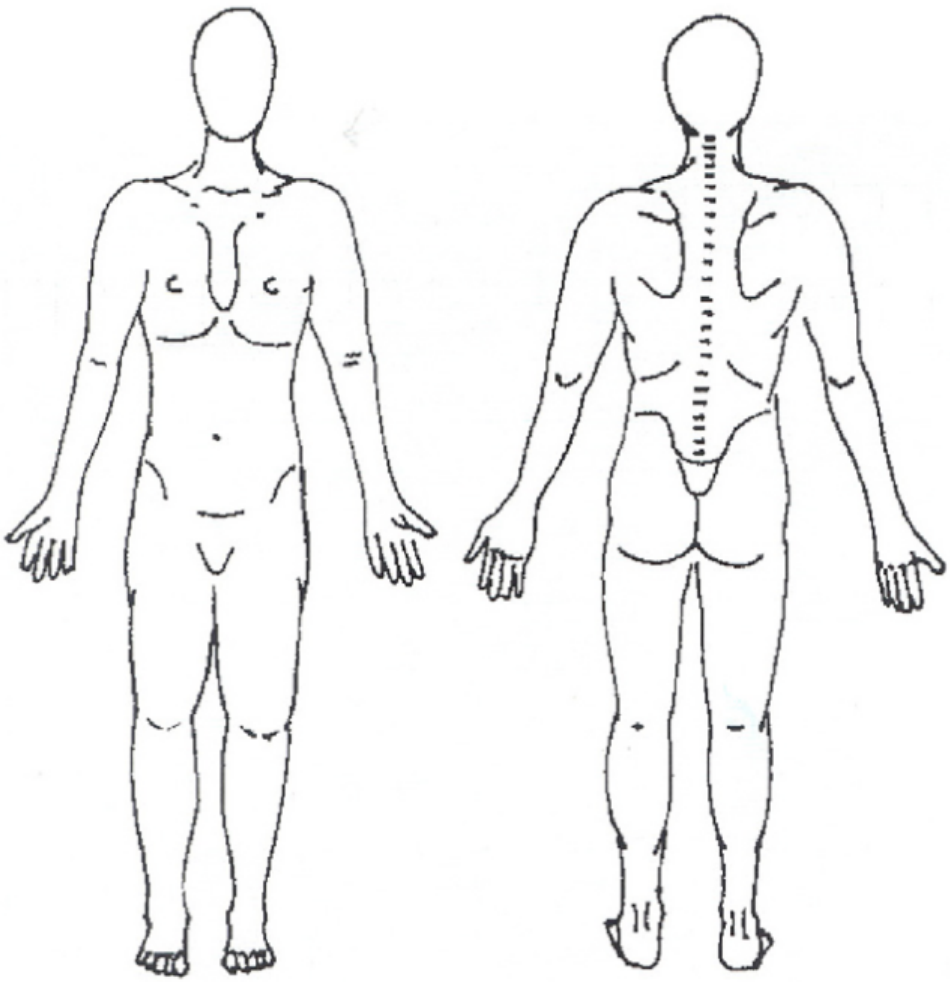
What are your goals for physical therapy? (E.g. “when I’m done with physical therapy I will be able to…”)
_____
Surgeries (list with dates)
_____

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 physical therapy treatment and services deemed necessary by my physical therapist, Derya Anderson PT, DPT. I am aware that the practice of physical therapy is not an exact science and I acknowledge that no guarantees have been made to me as to the results of these services provided by Dr. Anderson. It is Dr. Anderson's sincere intent to educate me on every process, from billing to treatment and eventually discharge from her services. Therefore, if "hands-on" manual or exercise techniques that are being used to retrain, recruit and restore postural alignment are not understood, it is my responsibility to obtain a clearer understanding of what the objectives and outcomes of my treatment are, and how we are trying to achieve them.

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

FOR MEDICARE BENIFICIARIES ONLY:

With the understanding that I can obtain physical therapy services that are covered by Medicare from a different participating provider, I choose, of my own free will, to receive this care from Dr. Derya Anderson instead. I refuse, of my own free will, to authorize the submission of a bill to Medicare.

_____ _____

Signature of patient Date