MISSOULA Bone & Joint Physical Therapy & Sports Medicine

New Patient or New Problem Physical Therapy Intake Information

Name: _____ Birth Date: _____ Age: _____

Preferred Name or Nickname: _____ Gender: ○ Female ○ Male

(√) Preferred Number to Contact: ○ Home _____ ○ Cell_____ ○ Work_____

Student: ○Yes ○ No School: _____ Employed: ○Yes ○ No

Referring Physician: _____ Primary Physician : _____

Reason for Today's Visit: (Complaint): _____
(which side? right, left, both)

Date Problem Began: _____

How did your injury occur (mechanism of injury): _____

Treatments: (current problem) Surgery: ○ Yes ○ No Physical Therapy: ○ Yes ○ No Injections: ○ Yes ○ No

What has helped the pain? Explain: _____

What makes the pain worse? Explain: _____

Current Condition: ○ Improving ○ Getting Worse ○ Staying the Same

What test(s) have been done?

○ MRI ○ X-Ray ○ Bone Scan ○ CT Scan Other _____

Known Allergies: _____

Please list all current medications, supplements or vitamins: _____

_____

_____

Do you have any heart problems or major medical conditions? _____

Have you ever had the same or similar problem before? ○ Yes ○ No ○ Not Sure

Have you missed any work due to this injury? ○ Yes ○ No Last date worked? _____

Are you obtaining Worker's Compensation for this injury? ○ Yes ○ No Employer: _____

Is there an attorney involved? ○ Yes ○ No

I certify that the above information is correct to the best of my knowledge. I will not hold my provider or any member of the staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient or Legal Guardian: _____ Date: _____

Office Use Only

Provider Reviewed:
Initials: _____ Date: _____

2/17/11