



## 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
--

