

In Motion Physical Therapy – Patient Intake Form

To ensure you receive a complete and thorough evaluation, provide us with the important background information on the following form. If you do not understand a question, your therapist will assist you. Thank you.

Full Name: _____ D.O.B: _____ Age: _____ SSN: _____ - _____ - _____

Address: Street: _____ Apt/Unit #: _____

Address: City, State, Zip: _____

Home Phone: _____ Cell Phone: _____ Marital Status (circle one): S M D W

Email address (internal use): _____ Emergency Contact: _____ Phone: _____

Employer: _____ Work Phone: _____ Can we leave a message: Y N

Diagnosis/Area to be treated: _____ Date of Injury/Onset of Pain: _____

Primary Physician: _____ How did you hear about In Motion? _____

PERSONAL MEDICAL HISTORY:

Have you ever been diagnosed as having any of the following conditions? Please check all that apply.

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Cancer: _____ | <input type="checkbox"/> Other Arthritis conditions | <input type="checkbox"/> Anemia | |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Headaches | <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Emphysema/Bronchitis | <input type="checkbox"/> Depression | <input type="checkbox"/> Chemical Dependency
(i.e., alcoholism) |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Asthma | <input type="checkbox"/> Stroke | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Heart Condition/Angina | <input type="checkbox"/> Allergies | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Circulation problems | <input type="checkbox"/> Unusual reaction to heat/cold | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Visual/Hearing difficulties | <input type="checkbox"/> Pregnant or planning to
become pregnant | <input type="checkbox"/> Thyroid problems |

SURGERY: List any surgeries or other conditions for which you have been hospitalized for, including the approximate date and reason for the surgery or hospitalization in the past 10 years:

<u>Date</u>	<u>Surgery/Hospitalization</u>	<u>Reason</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

INJURY: Describe any injuries for which you have been treated (including fractures, dislocations, sprains) and the approximate date of injury in the past 10 years:

<u>Date</u>	<u>Injury</u>
_____	_____
_____	_____

List any Prescription and over the counter medication you are currently taking (including pills, injections, and/or skin patches):

_____	_____	_____
_____	_____	_____
_____	_____	_____

PAIN:

Circle your level of pain: 0 = no pain, 10 = emergency room pain

0 1 2 3 4 5 6 7 8 9 10

Circle your normal (pre-injury) level of activity:

Sedentary Active Athletic

