# North 40 Physical Therapy Intake Form

## Physical Therapy Intake Form

**1. Please enter your information.**

Name: Date of Birth:

Billing Address: Apt./Unit #: City: State: Zip Code:

Gender:
○ Male ○ Female

Social Security #:

Home Phone: Mobile Phone: Email Address: Add to eNewsletter List?

Employer: Work Phone:

Preferred mode of communication:
○ Home Phone ○ Mobile Phone ○ Work Phone
○ Email Address

May we leave a message?
○ Yes ○ No

**2. Preferred Language:**

○ English ○ Spanish
○ Other

**If other, specify:**

**3. Emergency Contact:**

Name: Relationship:

Telephone #: Alt. Phone:

Signing this form confirms my authorization to disclose protected health information for medical purpose.

**4. Check below the protected health information you (the patient) authorize to be disclosed:**

○ All medical information ○ None
○ Only the following

**If only the following, please specify:**

5. Authorization will end:

- ○ Until revoked
- ○ Deceased
- ○ Specified date

If specified date, specify:

_____

6. Do you have Medical Insurance?

- ○ Yes
- ○ No

7. Primary Insurance

Primary Insurance Company _____ Member ID / Policy # _____

Group Number _____

Client Relationship to Insured
○ Self ○ Spouse ○ Child ○ Other

Insured Name _____ Insured Phone # _____ Insured Date of Birth _____ Insured Gender ○ Female ○ Male

Insured Street Address _____ Insured City _____ Insured State _____ Zip Code _____

Do you have secondary insurance?
○ Yes ○ No

8. Secondary Insurance

Secondary Insurance Company _____ Member ID / Policy # _____ Group Number _____

Client Relationship to Insured
○ Self ○ Spouse ○ Child ○ Other

Insured Name _____ Insured Phone # _____ Insured Date of Birth _____ Insured Gender ○ Female ○ Male

Insured Street Address _____ Insured City _____ Insured State _____ Zip Code _____

9. Is your insurance through your job?

- ○ Yes
- ○ No

I authorize the release of any medical information necessary to process my claim and payment of benefits.

Signature _____ Date _____

**10. What concern brings you in today?**

_____

**11. Inciting injury or trauma?**

- ○ Yes
- ○ No

**12. Date of Onset/Injury:**

_____

**13. If yes, describe:**

_____

**14. Is your injury:**

- ○ Auto related
- ○ Work Related
- ○ Accident Related

**15. Have you had surgery for this condition?**

- ○ Yes
- ○ No

**If yes, date of surgery?**

_____

**16. If yes, please describe surgery:**

_____

**17. Are your symptoms:**

- ○ Improved
- ○ Worse
- ○ Stable

**18. Please indicate if you have any of these concerns:**

- ☐ Pain
- ☐ Decreased Mobility
- ☐ Swelling/Edema
- ☐ Stiffness
- ☐ Loss of function

**19. If you have pain, is it:**

- ☐ Sharp?
- ☐ Dull?
- ☐ Shooting?
- ☐ Burning?
- ☐ Stabbing?
- ☐ Tingling?
- ☐ Intermittent?
- ☐ Constant?
- ☐ Deep?
- ☐ Superficial?
- ☐ Other

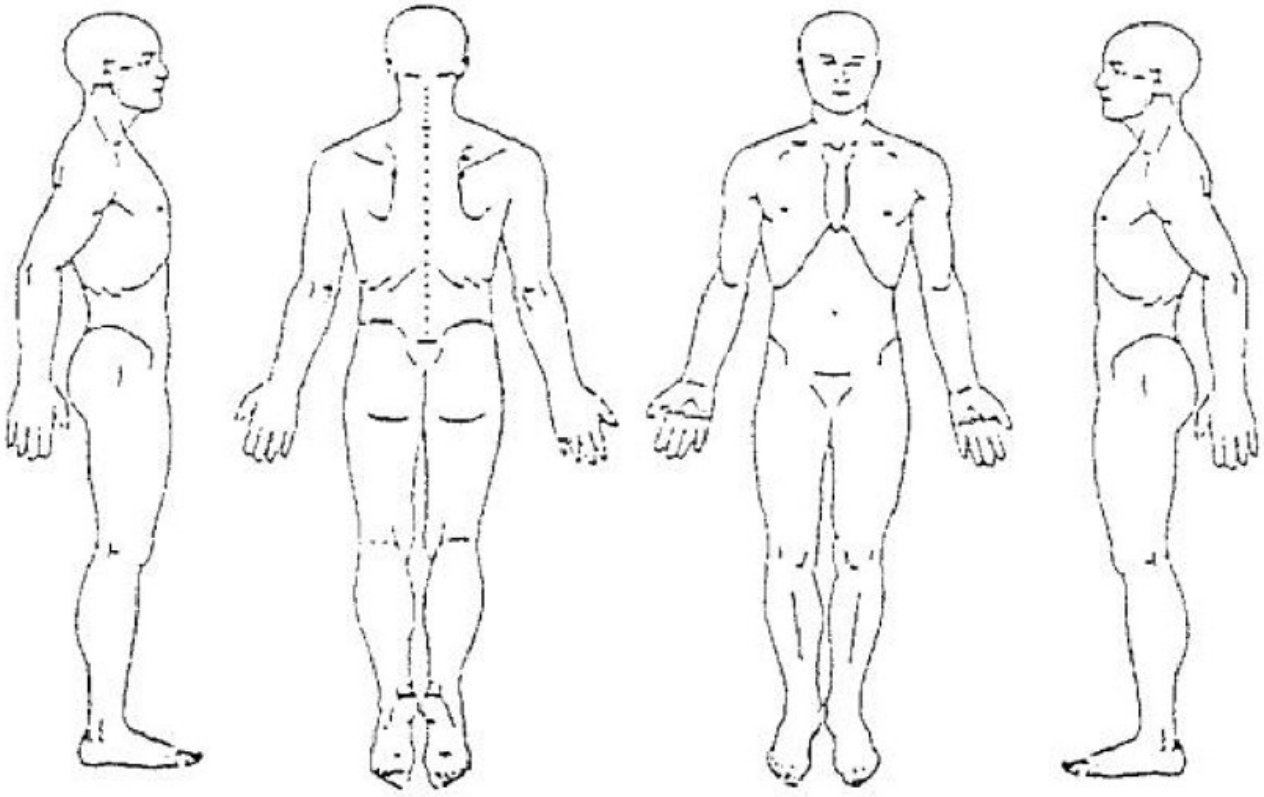
**If other, specify:**

_____

**20. How severe is your pain: 0= no pain, 10= excruciating pain?**

- ○ 0
- ○ 1
- ○ 2
- ○ 3
- ○ 4
- ○ 5
- ○ 6
- ○ 7
- ○ 8
- ○ 9
- ○ 10

**21.** Indicate on the chart below the location(s) of the problem:



**22. Is this problem affecting your daily life?**

- ○ Yes
- ○ No

23. If yes, please explain:

_____

24. Have you undergone any special tests for this condition?

- Yes
- No

25. If yes, please explain and include diagnosis:

_____

26. Have you been treated for this problem before?

- Yes
- No

27. If yes, have you been treated with:

- Physical Therapy
- Chiropractor
- Pilates
- Medication
- Other
- Massage
- Exercise
- Trigger Point Injection
- Surgery

If other, specify:

_____

28. Did this help?

- Yes
- No

29. Explain:

_____

30. Are you receiving home health services?

- Yes
- No

31. What goal(s) do you have for your physical therapy sessions?

_____

## Medical and Health History

**32. How would you rate your physical health?**

- ○ Excellent
- ○ Good
- ○ Fair
- ○ Poor

**33. Please answer the following questions:**

| | Yes | No |
|---|---|---|
| Do you experience dizziness/lightheadedness? | | |
| Have you had any falls over the past year? | | |
| Do you have problems with coordination? | | |
| Do you have blurred vision or other vision changes? | | |
| Do you have a hearing impairment? | | |
| Have you had a sudden change in bladder/bowel habits? | | |
| Have you had a recent change in weight or appetite? | | |
| Do you have any heat or cold intolerance? | | |
| Do you have nausea/vomiting? | | |
| Do you have bruising or bleeding problems? | | |
| Do you have shortness of breath or decrease in exercise tolerance? | | |
| Do you have osteoporosis/osteopenia? | | |
| Do you have any implanted devices? | | |
| Do you have a history of seizures? | | |
| Do you have recurrent headaches? | | |
| Do you have high blood pressure? | | |
| Do you have any heart problems? | | |
| Do you have diabetes? | | |
| Are you (or could you be) pregnant? | | |
| Have you had cancer? | | |
| Do you have a thyroid problem? | | |
| Have you been exposed to environmental toxins? | | |
| Do you have a history of COPD or lung problems? | | |
| Do you have a diagnosed neurological disease? ie Parkinsons, MS | | |
| Do you have a diagnosed autoimmune disease? | | |
| In the past month have you felt down or depressed? | | |
| In the past month have you lost interest in doing things? | | |

34. Past surgeries?

- Yes
- No

35. If yes, please list:

_____

_____

_____

_____

36. Do you smoke?

- Yes
- No
- Past

37. Drink alcohol?

- Yes
- No
- Past

38. Drink caffeine?

- Yes
- No
- Past

If yes, how many cups/day?

_____

39. Use pain medications?

- Yes
- No
- Past

If yes, what medication?

_____

40. Use recreational drugs?

- Yes
- No
- Past

If yes, what drug/s?

_____

41. Are you employed?

- Yes
- No

42. Occupation:

_____

43. Are there any physical demands of your job?

- ○ Yes
- ○ No

44. If yes, please explain:

_____

_____

_____

_____

45. Activity level:

- ○ Sedentary
- ○ Light
- ○ Moderate
- ○ Active
- ○ Extremely Active

46. If active, indicate the type and duration of exercise/sports:

_____

_____

_____

_____

## Family History

47. Does anyone in your family (parent or sibling) have a history of:

| | Yes | No |
|---|---|---|
| Diabetes | | |
| High Blood Pressure | | |
| Heart Problems | | |
| Cancer | | |