CLIENT INTAKE FORM

This information is strictly confidential. Your answers will help us determine if physical therapy can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. Please be as accurate and specific as possible.

PLEASE PROVIDE COMPLETED FORM PRIOR TO YOUR FIRST APPOINTMENT

Patient Information:

Patient Name:	Date: / /
Address:	Occupation:
Phone: (Mobile/Home)	Gender: ☐ Female ☐ Male
Email:	Date of Birth: / /

Medical Provider Information:

Provider Name:	Phone Number:
Address:	Fax Number:

Emergency Contact:

Name:
Relationship:
Phone Number:

I understand that all services rendered to me are charged directly to me and that I am personally responsible for payment. I understand that all examinations and treatments are to be paid for prior to their completion. I hereby authorize the Licensed Physical Therapist at Alpha Training & Rehab, PLLC to examine and treat my condition as she deems appropriate through the use of Physical Therapy and I give authority for these procedures to be performed.

_____

Signature Date

Medical History Intake Form

Current Health Report:

Please list your current health problems/concerns and an approximate onset date for which you are seeking physical therapy:

1.

2.

3.

What are you hoping to achieve with the help of our Physical Therapist?

Are your present complaints due to a specific injury?

☐ No ☐ Yes (Please describe briefly):

Is your condition worsening?

☐ No ☐ Yes

Have you had this condition before?

☐ No ☐ Yes (When?): _____

Do you have pain?

☐ No ☐ Yes

If Yes, is your pain:

☐ Constant ☐ Intermittent ☐ Activity Dependent

Is your condition interfering with any of the following:

☐ Work ☐ Sleep ☐ Daily Routine ☐ Other (please describe):

What activities aggravate your condition?

What, if anything, makes you feel better (positions of comfort, heat/ice, stretches, etc):

Have you had physical therapy previously?

☐ No ☐ Yes (when?):_____

Have you seen other Practitioners for this condition?

☐ No ☐ Yes (who and what treatments were/are being provided?):

Have you been treated by a Healthcare Provider for any other condition in the past year?

☐ No ☐ Yes (who and for what condition were you being treated?)

Are you currently taking any prescription medication?

☐ No ☐ Yes (please list medication name and dosages):

Have you ever been on frequent or prolonged antibiotic therapy (ie. erythromycin, penicillin, tetracycline, etc)?

☐ No ☐ Yes (what medication and for what condition):

Current non-prescription medications (ie. laxatives, antihistamines, etc):

☐ No ☐ Yes (please list):

Are you currently taking any vitamins or Supplements?

☐ No ☐ Yes (please list):

Allergies

☐ No ☐ Yes (please list):

Habits of Daily Living

Exercise:	Frequency:	Hours per Week:
☐ None ☐ Moderate ☐ Heavy	☐ <1x/week ☐ 1-3x/week ☐ 4-6x/week ☐ Daily	

Work Activity (Check all that apply):
☐ Sitting ☐ Standing ☐ Walking ☐ Light Labor ☐ Heavy Labor ☐ Other

Stress Level:
☐ High ☐ Moderate ☐ Low
Do you engage in any stress reduction activities?
☐ No ☐ Yes (please describe):

Are you currently on any psychotropic medication or receiving psychological counseling?
☐ No ☐ Yes

What meaningful activity would you like to do that you cannot currently tolerate?

Sleep Habits:
Hours/Night: _____ Please circle: Restftul/Restless
Are you sleeping through the night? ☐ No ☐ Yes

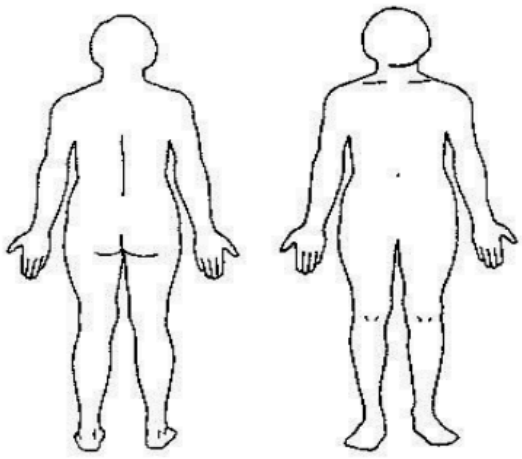
Tobacco Consumption
Do you smoke? ☐ No ☐ Yes (how many/day):_____ For how long? _____
Have you ever smoked? ☐ No ☐ Yes (for how long?) _____

Do you eat regular meals (ex. 3x/day)? ☐ No ☐ Yes
Do you sit down to meals? ☐ No ☐ Yes

General Health History

Please list any major accidents, serious falls or injuries (with dates):
Broken bones, head injuries:
List surgeries/hospitalizations (with dates):
Any x-rays or imaging within the last 10 years (with dates)?

Please mark where you are experiencing pain or symptoms:



Please mark your pain on this scale:

0_____1_____2_____3_____4_____5_____6_____7_____8_____9_____10

No pain Worst Pain

Systems Review:

Please mark whether if you now have, or if you ever have experienced any of the following:

Condition	Yes	No		Yes	No
Asthma, Bronchitis, Emphysema			Cancer		
Shortness of Breath, Chest Pain			Arthritis		
Heart Disease, or Angina			Stroke/TIA		
Heart Attack, or Surgery			Diabetes		
High Blood Pressure			Gout		
Pacemaker			Anemia		
Blood Clot or Emboli			Allergies		
Infectious Diseases (ie. STD/STI)			Osteoporosis		
Visual or Hearing Problems			Hernia		
Thyroid Dysfunction			Weakness		
Dizziness or Fainting			Weight Loss >10 lbs		
Surgical Implants			Weight Gain >10 lbs		
Bladder Dysfunction			Bowel Dysfunction		
Sexual Dysfunction			History of Low Back Pain		

Are you aware of your diagnosis?

☐ No ☐ Yes

Are you currently pregnant?

☐ No ☐ Yes (due date): _____/_____/_____

_____

Signature Date