SPORTS CENTER PHYSICAL THERAPY
NEW PATIENT INTAKE FORM

PATIENT NAME:_____ _____
Last Name **First Name** **Middle Initial**

Today's Date:_____	Date of Birth:_____
Mailing Address:_____ _____	Phone Number (best to reach you at during the day): _____ ☐Cell Email Address:_____
Responsible Party: (If Minor)_____	How did You hear about us?_____ Returning patient? ☐YES ☐ NO

Name of your Primary Care Doctor (PCP):_____
Name of your Referring Physician (if other than PCP):_____
What body part are you here for today?_____ ☐ RIGHT ☐ LEFT
When did your symptoms begin?_____
Was there a specific injury or event that caused this problem? ☐ NO ☐ YES (describe)_____
_____
Have you had this physical therapy for this problem before? ☐ NO ☐ YES
Have you had any other types of treatments to address this problem ☐ NO ☐ YES (circle all that apply)
*massage injections psychotherapy chiropractic occupational therapy Other:*_____
Diagnostic Imaging: Have you had any of the following tests for this problem?
☐ X-Ray ☐ MRI ☐CT scan ☐EMG/Nerve Conduction Study ☐Cardiac/Stress Test ☐Other:_____
Results (if known)_____
Have you had physical therapy this calendar year? ☐ NO ☐ YES: When were you discharged? _____
Is your injury work related? ☐ NO ☐ YES: Date of Injury: _____
Is your injury related to a motor vehicle accident? ☐ NO ☐ YES: Date of Accident:_____

SOCIAL HISTORY:
What is your Occupation?_____
(circle one) *Full-time Part-time Retired Not working Unable to work (due to this problem)*
Job Requirements: ☐prolonged sitting ☐ computer/desk work ☐ prolonged standing ☐ bending/lifting ☐driving
Do you exercise regularly? ☐ NO ☐ YES: (type/frequency)_____
Do you have hobbies or leisure activities? ☐ NO ☐YES:_____
_____

MEDICAL HISTORY: Please check any conditions that you have or *have been treated for*

☐ Diabetes	☐ Stroke/TIA (mini stroke)	☐ Chemical Dependency/Alcoholism
☐ Heart Attack	☐ Coronary Heart Disease	☐ High Blood Pressure
☐ Atrial Fibrillation	☐ Thyroid Disease	☐ Depression/Anxiety
☐ Rheumatoid Arthritis	☐ Hepatitis/Liver Disease	☐ Kidney Disease
☐ Neuropathy	☐ Gout	☐ DVT/Pulmonary Embolism
☐ Lyme's Disease	☐ Osteoarthritis/DJD	☐ Fracture(s):_____
☐ Skin conditions	☐ Osteoporosis	☐ Neurological Disease
☐ Infectious Disease	☐ Immunosuppression	☐ Respiratory Disease (Asthma)
☐ Ulcers/GERD/Acid Reflux	☐ Incontinence	☐ Cancer:_____

List <u>any orthopedic surgeries</u> you have had (when/year):_____

_____

List any Allergies (food, environmental, medications, latex):_____

_____

List all medications, vitamins, herbs, supplements and over the counter drugs you currently take:_____

_____

_____

Do you have a pacemaker? ☐ NO ☐ YES Other implanted medical device? ☐ NO ☐ YES_____

Date of your last physical examination: _____

Are you pregnant or is there a possibility you may be pregnant? ☐ NO ☐ YES ☐ N/A

What is your main reason for coming to physical therapy today (check all that apply):

☐ Post/pre-surgery
☐ Pain
☐ Numbness/tingling
☐ Stiffness
☐ Weakness
☐ Balance loss
☐ Recent fall(s)
☐ Other:_____

☐ Functional Impairment

Inability/difficulty doing any of the following activities:

☐ Bathe/Shower	☐ Housework/School Work
☐ Get Dressed (shoes/socks)	☐ Work/Job Related Tasks
☐ Walking (short/long distances)	☐ Driving
☐ Sleeping (stomach/back/side)	☐ Sports:_____
☐ Regular Exercise Program	☐ Hobbies/Leisure Activities

GOALS: Please list what you hope to achieve by attending physical therapy for this problem: _____

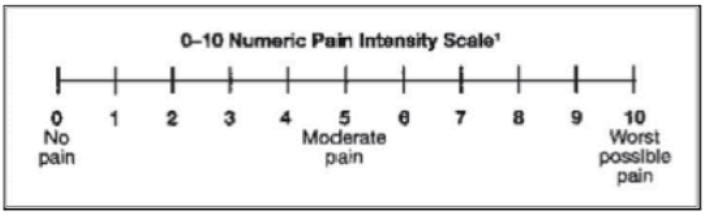
_____

_____

PAIN ASSESSMENT QUESTIONNAIRE

Using the following scale rate your pain on a scale of 1-10

- At this current time: _____/10
- The Worst it's been in the last 72 hours:_____/10
- The Best it's been in the last 72 hours:_____/10



Which of the following words best describe your pain complaints? (you may circle more than one)

dull/ache burning sharp/stabbing constant comes/goes numb/tingling stiff/tightness throbbing intense

Since the onset would you say your symptoms are: ☐ getting worse ☐ improving ☐ staying the same

At what time(s) are your symptoms the **worst**? ☐ when I get up (morning) ☐ afternoon ☐ evening ☐ overnight

What, if anything, makes your symptoms **better**?_____

_____

What, if anything, makes your symptoms **worse**?_____

_____

Do your symptoms improve once you start moving? ☐ NO ☐ YES: ☐ within 30-60 minutes ☐ more than 1 hour

Does the pain wake you up at night? ☐ NO ☐ YES IF yes, are you able to fall back to sleep? ☐ NO ☐ YES

ASSIGNMENT and RELEASE:

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ _____ and assign directly to SCPT all insurance benefits, if any, payable to me for services rendered. I understand that I am responsible for all charges whether or not paid by insurance. I hereby authorize SCPT to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I understand that SCPT contracts internships with colleges. I authorize observation and/or treatment by said interns.

_____ _____ _____

Responsible Party Signature **Relationship** **Date**