Patient Intake Form

Name: _____ Date: ____/____/_____
Date of Birth: ____/____/_____ Email: _____
Mailing Address: _____
Phone Number (Home): _____ Phone Number (Cell): _____
Sex: M or F Marital Status: _____ Occupation: _____
If Patient is a minor (under the age of 18):
Guardian's name: _____ Relationship: _____

Emergency Contact:
Name: _____ Relationship: _____
Phone Number: _____

Health Insurance:
Insurance Company: _____ Policy Holder Name: _____
ID Number: _____

Referring Physician:
Name: _____ Office Name: _____

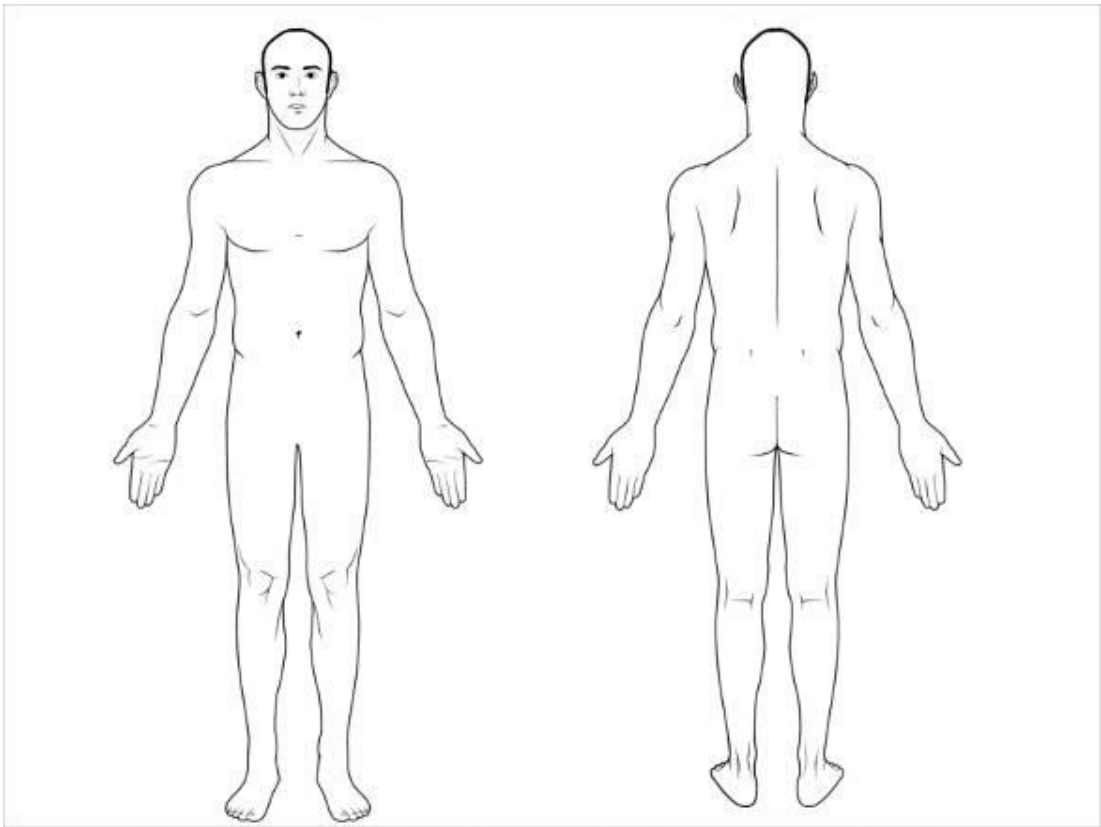
Primary Care Physician:
Name: _____ Office Name: _____

Other:
Are you currently seeing someone else for any kind of therapy? Y or N
If Yes, where/what kind? _____

How did you hear about Dynamic PTSC? _____

Patient Initials: _____

Injury Information:
What body part are we seeing you for? _____
Onset of symptoms or date of injury: _____
What tests have been completed for this injury? XRAY MRI CT Scan Other _____ None
What best describes your pain? Achy Sharp Burning Stabbing Tingling Other _____
On a scale of 0-10 (0= no pain and 10= worst pain imaginable) my pain at best is _____ and at worst is _____.
Please mark where you have symptoms of the following image:



Are you currently taking any medications or supplements for your symptoms? Y or N
If Yes, what are you taking? _____

What are your goals for physical therapy? _____

Patient Initials: _____

Medical History:

I have a history of (please circle all that apply):

High Blood Pressure	Recent weight loss/gain
Heart Disease	Lung disease
Diabetes	Thyroid condition
Epilepsy	Low blood sugar
Hearing loss	Cancer
Asthma	Impaired vision
Osteoporosis	Fractures
Frequent falls	Ringing in ears
Shortness of breath	Dizziness
Angina (chest pain)	Concussion
Arthritis	Difficulty swallowing
Stroke	Impaired memory
Depression	Anxiety

Have you fallen recently? Y or N
Do you have a pacemaker or surgical implant? Y or N
Are you pregnant: Y or N
I have the following allergies: _____
Please list any serious illnesses, accidents, and/or surgeries: _____
_____
_____
Please list all your medications: _____
_____
Have you been seen by a physical therapist before? Y or N
If yes, what for? _____

How much caffeine do you consume daily? _____
Do you smoke? Y or N If yes, how long have you been a smoker? _____ cigarettes/day? ___
How many days a week do you drink alcohol?

The above is true to the best of my knowledge.

Signature: _____ Date: _____

Patient Initials: _____

Attendance Policy:
Consistent attendance and adherence to the planned treatment regimen is paramount to your care and recovery. We require a 24 hour cancellation notice for all appointments. If notice is not given, you may be charged a fee for the missed appointment.

Consent for Treatment:
I hereby authorize Dynamic Physical Therapy and Sports Conditioning to evaluate and treat my injury. I understand there is no guarantee that my condition will improve. I further understand that response to physical therapy evaluations and treatments vary from person to person and on rare occasions a treatment session may aggravate symptoms.

Notice of privacy practice:
Dynamic Physical Therapy and Sports Conditioning is committed to protecting our patients' health information and privacy. In compliance with Federal HIPPA Regulations, therapists and staff will make their best efforts to ensure that your protected health information is kept private at all times. By signing below, I acknowledge that I may request a copy of Dynamic Physical Therapy and Sports Conditioning's Notice of Privacy Practices.

Authorization To Release Protected Health Information:
I hereby authorize one or all of the designated parties listed below to request and receive the release of any protected health information

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____Relationship: _____

Patient Name:_____

Signature:_____ Date:_____

Patient Initials: _____