INTAKE FORM

Date:
Name:
Phone:
Email:
DOB:
Insured Party Name and DOB (if different):
Prefered Pronoun:

Address:
Primary Care Physician:
Referring Provider (if applicable)

CURRENT SYMPTOMS

Where are you currently having symptoms?

When (approximately) did your present pain start?

How (gradually, suddenly, injury)?

My symptoms are currently: **Getting better / About the same / Getting worse**

Have you received any treatment for this problem?

Have you ever had this problem before: **Y N**

If so, how was the problem treated?

How do you sleep at night? **Fine** **Moderate Difficulty** **Only with medication**

What are your personal goals for therapy?

SYMPTOM INTENSITY

Average for the last 48 hours:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain Imaginable

Best for the last 48 hour

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain Imaginable

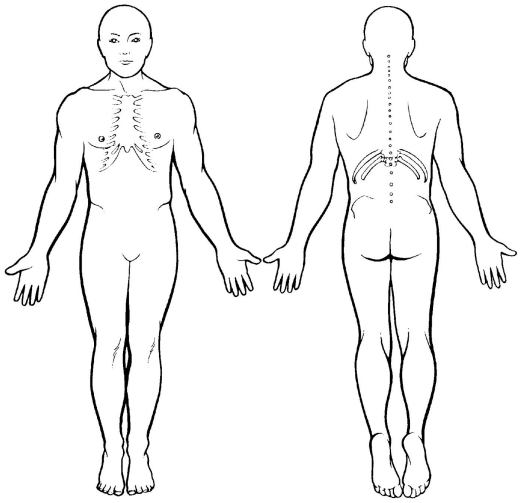
Worst for the last 48 hours:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain Imaginable

Please circle the number below which best your overall average level of function

Able to do everything 0 1 2 3 4 5 6 7 8 9 10 Unable to do anything

Body Chart: Please mark the area where you feel pain on the chart to the right



What makes your symptoms **worse?**

What makes your symptoms **better?**

Any times of the day that are better/ worse?

LIFESTYLE:

Occupation:

Describe your regular exercise routine:

Alcohol: **Y N** if yes how much per week**:** Smoke: **Y N** if yes, how many years
Drug Use: **Y N**
Pregnant: **Y N** if yes how many months # of pregnancies: # of live births:
Stress Level: **LOW MOD HIGH**

During the past month, have you often been bothered by feeling down, depressed, or hopeless? **Y N**
During the past month, have you often been bothered by little interest or pleasure in doing things? **Y N**
Do you feel safe at home / in current living situation: **Y N**

PAST MEDICAL HISTORY

Do you have or have ever been told you have any of the following:
(please circle all that apply)

Cancer	Lung Disease	High CHolesterol
Diabetes	Liver or Kidney Disease	Rheumatoid Arthritis
Heart Disease	Thyroid Dysfunction	Anxiety
High Blood Pressure	Stroke	OTHER: (please list)
Osteoporosis	Chest pain	_____

Please list all Current Medications and Supplements:

Blood Thinners: **Y** **N** for how long:

Have you had a recent illness (explain if yes)?

Allergies:

Past Surgical HIstory: (list all with date)

Past Injuries:

Have you had any X-Rays, MRI, CT scan or other imaging studies?

Personal Impact:

Identify up to 3 important activities that you are unable to do or are having difficulty with as a result of your problem. List them below and give a rating 0-10:

Unable to perform = 0 **Able to perform at the same level prior to symptoms = 10**

1 2 3 4 5 6 7 8 9 10

1. **Rating**

2. **Rating**

3. **Rating**

Avg:

If there is anything else you would like to share to aid in providing you with exceptional care please note it below:

I understand that my diagnosis and treatment plan will be discussed during my appointment and that I have the right to question and or refuse any treatment proposed.

CONDITIONS AND CONSENT FOR TREATMENT

As a patient you have the right to be informed about your health condition(s) and about recommended rehabilitation treatments. This document provides information that you may use for the purpose of deciding to give or to withhold your consent to be provided with care at Infinite Motion Physical Therapy, LLC.

I, _____, request and consent to examination and treatment for Physical Therapy and/or
personal training. I further understand that I have the right to ask questions about:

- all aspects of examination and treatment, my condition, diagnosis or prognosis
- the nature or goals and potential benefits of any proposed care
- the inherent risks, complications, or side effects of treatment
- the likelihood of improvement or success following intervention
- reasonable, available alternatives to the suggested care and character of treatment

Potential risks I may experience include an increase in my current level of pain or discomfort, or an aggravation of my existing injury or condition. This discomfort is usually temporary; if it does not subside in 24 hours, I agree to contact my therapist. Potential benefits I may experience include an improvement in my symptoms and an increase in my ability to perform movement and daily activities. I may experience increased strength, awareness, flexibility and endurance with activity. I may experience decreased pain and discomfort. I will learn strategies for managing my condition and resources available to me will be shared.

If I do not wish to participate in the therapy program, I will discuss my medical, surgical or pharmacological alternatives with my physician or primary care provider. It is anticipated that physical rehabilitation will allow improved function through decreased pain, increased strategies for managing pain, weakness, or immobility.

Print Name:_____

Signature: _____ Date: