PTplus

Patient Intake Form

To help save you some time at your first visit, we're asking you to please complete some information about yourself, your pain or injury, and insurance details prior to your appointment.

Full Name: _____ DOB: _____

Are you filling this intake form out for yourself or on behalf of someone else? Please select one

Social Security Number *_optional_ (Depending on your benefits and insurance coverage, your social security number may be required) _____

Gender: ☐ Male ☐ Female ☐ Male ☐ Non-binary ☐ Prefer not to say

Marital Status: ☐ Single ☐ Married ☐ Other

Please provide your contact information here. We want to stay connected with you regarding your appointments or may have questions regarding your insurance or benefits.

Home Phone: _____ Mobile Phone: _____ Email: _____

Address: _____ Unit # _____

City: _____ State: _____ Zip Code: _____

Is your injury related to any of the following? Please select one

If auto related, please provide the following information about your auto incident:

Insurance Company Name: _____ Claim Number: _____

Date of Incident: _____ Accident State: _____ Adjuster: _____

If work related, please provide the following information about your incident:

Insurance Company Name: _____ Claim Number: _____

Date of Incident: _____ Case Manager: _____ Adjuster: _____

Please select your employment status: Please select one

Employers Information:

Name: _____ Phone: _____

Address: _____ Unit # _____

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City: _____ State: _____ Zip Code: _____

In the event of an emergency, who would you like us to contact?

Name: _____ Phone: _____

Relationship: _____

How did you hear about us? Please select one _____

Insurance Questions

Are you a Medicare patient? ☐ Yes ☐ No

Do you have an insurance you'd like to use? ☐ Yes ☐ No

If yes, please complete the following:

Insurance Plan Name: _____ Policy ID: _____

Group # _____ Phone Number: _____ Are you the policy holder? ☐ Yes ☐ No

The next series of questions are related to your medical history. This information will assist our clinical team in providing the best treatment plan for your condition.

Height: _____ft _____inches Weight: _____

Tell us about your injury and/or symptoms. Approximate Date of Injury: _____

Diagnosis as stated to you by physician: _____

Description of how injury occurred: _____

What Regions are affected by your current symptoms? (please select all that apply)

☐ Head/Neck ☐ Upper Back ☐ Shoulder ☐ Arm ☐ Hand/Wrist

☐ Hip ☐ Pelvis ☐ Lower back ☐ Knee ☐ Leg

☐ Ankle/Foot ☐ Other: _____

Have you received any previous treatment for this condition? ☐ Yes ☐ No

Please indicate the previous treatment you received for this condition: _____

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What kind of pain are you experiencing? (please select all that apply)

☐ Tenderness ☐ Spasm ☐ Numbness ☐ Tingling ☐ Aching

☐ Sharp ☐ Shooting ☐ Dull ☐ Other: _____

My pain/symptoms are **worse** _____. (please select all that apply)

☐ In the morning ☐ During the day ☐ At night ☐ With activity ☐ At Rest

☐ None ☐ Symptoms come and go ☐ Symptoms are constant

My pain/symptoms are **best** _____. (please select all that apply)

☐ In the morning ☐ During the day ☐ At night ☐ With activity ☐ At Rest

☐ None ☐ Symptoms come and go ☐ Symptoms are constant

Pease indicate the intensity of current, best, and worst pain levels over the past 24 hours on a scale of 0 (no pain) to 10 (worst pain imaginable)

Current: 0_____ Best: 0_____ Worst: 0_____

Have you ever had any of the following for this issue before, and if so, what is the treatment date?

Please select one _____ Treatment Date: _____

Have you ever had any of the following diagnostic tests for this issue before? Please select one

Tell us about other forms of treatment you've had for this issue in the past: Please select one

Have you fallen within the last year? ☐ Yes ☐ No

If yes, how many times have you fallen within the last year? _____

Do you feel unsteady when standing or walking? ☐ Yes ☐ No

Do you worry about falling? ☐ Yes ☐ No

Who's your referring doctor? ☐ I don't have a referring doctor

Doctor name: _____

Referring Dr Phone: _____ Referring Dr prescription date: _____

Please select the conditions that you have been or are presently being treated for. This information helps your therapist develop a treatment plan that will be best for you.

☐ Acquired respiratory distress syndrome ☐ Allergies ☐ Angina

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☐ Anxiety or Panic disorders	☐ Arthritis	☐ Asthma
☐ Back Injury	☐ Bleeding disorders	☐ Bowel/bladder abnormalities
☐ Cancer	☐ COPD	☐ Congestive heart failure
☐ Defibrillator	☐ Degenerative disc disease	☐ Depression
☐ Diabetes	☐ Dizzy or fainting spells	☐ Emphysema
☐ Epilepsy or seizure disorder	☐ Fracture	☐ Headaches
☐ Hearing impairment	☐ Heart attack	☐ Hepatitis A, B, C
☐ Hernia	☐ High blood pressure	☐ HIV/AIDS
☐Hypoglycemic	☐ Immunosuppressant condition	☐ Kidney problems
☐ Liver/Gallbladder problems	☐ Metal implants	☐ Multiple sclerosis
☐ Nausea/vomiting	☐ Osteoporosis	☐ Pacemaker
☐ Parkinson's disease	☐ Peripheral vascular disease	☐ Pregnancy
☐ Ringing in your ears	☐ Sexual dysfunction	☐ Skin abnormalities
☐ Smoking	☐ Special diet guidelines	☐ Stroke or TIA
☐ Tuberculosis	☐ Upper gastrointestinal disease	☐ Visual impairment

Are you currently taking any medications? ☐ Yes ☐ No

(if yes, please list below)

Medication: _____ Dosage: _____

Medication: _____ Dosage: _____

Medication: _____ Dosage: _____

Medication: _____ Dosage: _____

Medication: _____ Dosage: _____

Medication: _____ Dosage: _____

Medication: _____ Dosage: _____

Medication: _____ Dosage: _____

What are your goals for therapy at this time?

_____

_____

_____

Is there any other information regarding your medical history that is important for us to know?

_____

_____

_____

_____

_____