High Country Physical Therapy Intake Form

1. Please enter your information.

Name: Date of Birth:

Billing Address: Apt./Unit #: City: State: Zip Code:

Gender:
○ Male ○ Female

Social Security #:

Home Phone: Mobile Phone: Email Address: Add to eNewsletter List?

Employer: Work Phone:

Preferred mode of communication:
○ Home Phone ○ Mobile Phone ○ Work Phone
○ Email Address

May we leave a message?
○ Yes ○ No

2. Preferred Language:

○ English ○ Spanish
○ Other

If other, specify:

3. Emergency Contact:

Name: Relationship:

Telephone #: Alt. Phone:

Signing this form confirms my authorization to disclose protected health information for medical purpose.

4. Check below the protected health information you (the patient) authorize to be disclosed:

○ All medical information ○ None
○ Only the following

If only the following, please specify:

5. Authorization will end:

- ○ Until revoked
- ○ Deceased
- ○ Specified date

If specified date, specify:

_____

6. Do you have Medical Insurance?

- ○ Yes
- ○ No

7. Primary Insurance

Primary Insurance Company _____ Member ID / Policy # _____

Group Number _____

Client Relationship to Insured
○ Self ○ Spouse ○ Child ○ Other

Insured Name _____ Insured Phone # _____ Insured Date of Birth _____ Insured Gender ○ Female ○ Male

Insured Street Address _____ Insured City _____ Insured State _____ Zip Code _____

Do you have secondary insurance?
○ Yes ○ No

8. Secondary Insurance

Secondary Insurance Company _____ Member ID / Policy # _____ Group Number _____

Client Relationship to Insured
○ Self ○ Spouse ○ Child ○ Other

Insured Name _____ Insured Phone # _____ Insured Date of Birth _____ Insured Gender ○ Female ○ Male

Insured Street Address _____ Insured City _____ Insured State _____ Zip Code _____

9. Is your insurance through your job?

- ○ Yes
- ○ No

I authorize the release of any medical information necessary to process my claim and payment of benefits.

Signature _____ Date _____

10. What concern brings you in today?

_____

11. Inciting injury or trauma?

- ○ Yes
- ○ No

12. Date of Onset/Injury:

_____

13. If yes, describe:

_____

14. Is your injury:

- ○ Auto related
- ○ Work Related
- ○ Accident Related

15. Have you had surgery for this condition?

- ○ Yes
- ○ No

If yes, date of surgery?

_____

16. If yes, please describe surgery:

_____

17. Are your symptoms:

- ○ Improved
- ○ Worse
- ○ Stable

18. Please indicate if you have any of these concerns:

- ☐ Pain
- ☐ Decreased Mobility
- ☐ Swelling/Edema
- ☐ Stiffness
- ☐ Loss of function

19. If you have pain, is it:

- ☐ Sharp?
- ☐ Dull?
- ☐ Shooting?
- ☐ Burning?
- ☐ Stabbing?
- ☐ Tingling?
- ☐ Intermittent?
- ☐ Constant?
- ☐ Deep?
- ☐ Superficial?
- ☐ Other

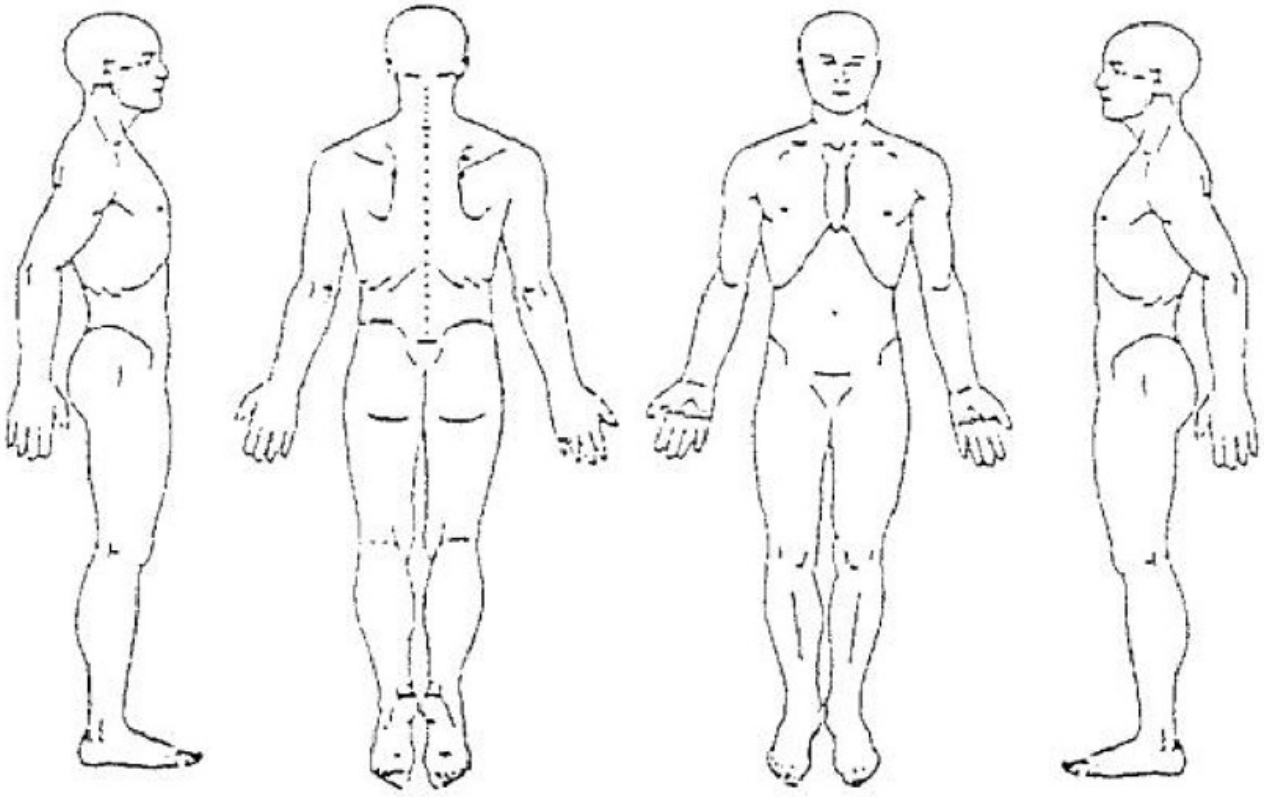
If other, specify:

_____

20. How severe is your pain: 0= no pain, 10= excruciating pain?

- ○ 0
- ○ 1
- ○ 2
- ○ 3
- ○ 4
- ○ 5
- ○ 6
- ○ 7
- ○ 8
- ○ 9
- ○ 10

21. Indicate on the chart below the location(s) of the problem:



22. Is this problem affecting your daily life?

- ○ Yes
- ○ No

23. If yes, please explain:

_____

24. Have you undergone any special tests for this condition?

- Yes
- No

25. If yes, please explain and include diagnosis:

_____

26. Have you been treated for this problem before?

- Yes
- No

27. If yes, have you been treated with:

- Physical Therapy
- Chiropractor
- Pilates
- Medication
- Other
- Massage
- Exercise
- Trigger Point Injection
- Surgery

If other, specify:

_____

28. Did this help?

- Yes
- No

29. Explain:

_____

30. Are you receiving home health services?

- Yes
- No

31. What goal(s) do you have for your physical therapy sessions?

_____

Medical and Health History

32. How would you rate your physical health?

- ○ Excellent
- ○ Good
- ○ Fair
- ○ Poor

33. Please answer the following questions:

	Yes	No
Do you experience dizziness/lightheadedness?		
Have you had any falls over the past year?		
Do you have problems with coordination?		
Do you have blurred vision or other vision changes?		
Do you have a hearing impairment?		
Have you had a sudden change in bladder/bowel habits?		
Have you had a recent change in weight or appetite?		
Do you have any heat or cold intolerance?		
Do you have nausea/vomiting?		
Do you have bruising or bleeding problems?		
Do you have shortness of breath or decrease in exercise tolerance?		
Do you have osteoporosis/osteopenia?		
Do you have any implanted devices?		
Do you have a history of seizures?		
Do you have recurrent headaches?		
Do you have high blood pressure?		
Do you have any heart problems?		
Do you have diabetes?		
Are you (or could you be) pregnant?		
Have you had cancer?		
Do you have a thyroid problem?		
Have you been exposed to environmental toxins?		
Do you have a history of COPD or lung problems?		
Do you have a diagnosed neurological disease? ie Parkinsons, MS		
Do you have a diagnosed autoimmune disease?		
In the past month have you felt down or depressed?		
In the past month have you lost interest in doing things?		

34. Past surgeries?

- Yes
- No

35. If yes, please list:

_____

_____

_____

_____

36. Do you smoke?

- Yes
- No
- Past

37. Drink alcohol?

- Yes
- No
- Past

38. Drink caffeine?

- Yes
- No
- Past

If yes, how many cups/day?

_____

39. Use pain medications?

- Yes
- No
- Past

If yes, what medication?

_____

40. Use recreational drugs?

- Yes
- No
- Past

If yes, what drug/s?

_____

41. Are you employed?

- Yes
- No

42. Occupation:

_____

43. Are there any physical demands of your job?

- ○ Yes
- ○ No

44. If yes, please explain:

_____

_____

_____

_____

45. Activity level:

- ○ Sedentary
- ○ Light
- ○ Moderate
- ○ Active
- ○ Extremely Active

46. If active, indicate the type and duration of exercise/sports:

_____

_____

_____

_____

Family History

47. Does anyone in your family (parent or sibling) have a history of:

	Yes	No
Diabetes		
High Blood Pressure		
Heart Problems		
Cancer		

48. _____