



## Patient Intake

| Patient Information  |  |       |
|--|--|-------|
| First:   | Middle:  | Last: |
| Gender: <input type="radio"/> Male <input type="radio"/> Female  | Social Security:   |       |
| Date of Birth:   | Marital Status: <input type="radio"/> Single <input type="radio"/> Married <input type="radio"/> Other |       |
| Student Status: <input type="radio"/> Fulltime <input type="radio"/> Part time <input type="radio"/> N/A |  |       |
| <input type="radio"/> Patient Under 18   | Parent/Guardian Name:  |       |

| Mailing Address |        |                  |
|-----------------|--------|------------------|
| Street:         |        |                  |
| City:           | State: | Zip/Postal Code: |

| Contact  |               |
|--|---------------|
| Email:   |               |
| Home Phone:  | Mobile Phone: |
| Preferred Contact Method: <input type="radio"/> Home <input type="radio"/> Mobile Phone  |               |
| Emergency Contact  |               |
| Contact Name:  |               |
| Contact Phone:   |               |
| Relationship: <input type="radio"/> Spouse <input type="radio"/> Parent <input type="radio"/> Sibling <input type="radio"/> Guardian <input type="radio"/> Other _____ |               |

| Employer |        |                  |
|----------|--------|------------------|
| Name:    |        |                  |
| Street:  |        |                  |
| City:    | State: | Zip/Postal Code: |
| Phone:   |        |                  |

Who referred you to Wellspring Physical Therapy? \_\_\_\_\_

Physician that referred you: \_\_\_\_\_

I hereby authorize Wellspring Physical Therapy to be paid directly by my insurance company for their services. I understand that I am financially responsible for all charges not covered or paid by my insurance. I hereby authorize Wellspring Physical Therapy or my insurance company to release all information necessary to process and secure payment for my claim.

Patient or Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_



| Patient Information   |             |
|---|-------------|
| Name:   | Date:       |
| Height:                      Weight:  | Age:        |
| Are you currently working? <input type="radio"/> Yes <input type="radio"/> No |             |
| Reason for visit:   |             |
| Date of injury if known:  |             |
| Occupation:   | Job Duties: |

**Medical History**

**Existing Conditions**

|                      |  |                         |  |                      |  |
|----------------------|--|-------------------------|--|----------------------|--|
| Allergies            | <input type="radio"/> Yes <input type="radio"/> No | Dizzy Spells            | <input type="radio"/> Yes <input type="radio"/> No | MRSA                 | <input type="radio"/> Yes <input type="radio"/> No |
| Anemia               | <input type="radio"/> Yes <input type="radio"/> No | Emphysema/Bronchitis    | <input type="radio"/> Yes <input type="radio"/> No | Multiple Sclerosis   | <input type="radio"/> Yes <input type="radio"/> No |
| Anxiety              | <input type="radio"/> Yes <input type="radio"/> No | Fibromyalgia            | <input type="radio"/> Yes <input type="radio"/> No | Muscular Disease     | <input type="radio"/> Yes <input type="radio"/> No |
| Arthritis            | <input type="radio"/> Yes <input type="radio"/> No | Fractures               | <input type="radio"/> Yes <input type="radio"/> No | Osteoporosis         | <input type="radio"/> Yes <input type="radio"/> No |
| Asthma               | <input type="radio"/> Yes <input type="radio"/> No | Gallbladder Problems    | <input type="radio"/> Yes <input type="radio"/> No | Parkinsons           | <input type="radio"/> Yes <input type="radio"/> No |
| Autoimmune Disorder  | <input type="radio"/> Yes <input type="radio"/> No | Headaches               | <input type="radio"/> Yes <input type="radio"/> No | Rheumatoid Arthritis | <input type="radio"/> Yes <input type="radio"/> No |
| Cancer               | <input type="radio"/> Yes <input type="radio"/> No | Hearing Impairment      | <input type="radio"/> Yes <input type="radio"/> No | Seizures             | <input type="radio"/> Yes <input type="radio"/> No |
| Cardiac Conditions   | <input type="radio"/> Yes <input type="radio"/> No | Hepatitis               | <input type="radio"/> Yes <input type="radio"/> No | Smoking              | <input type="radio"/> Yes <input type="radio"/> No |
| Cardiac Pacemaker    | <input type="radio"/> Yes <input type="radio"/> No | High Cholesterol        | <input type="radio"/> Yes <input type="radio"/> No | Speech Problems      | <input type="radio"/> Yes <input type="radio"/> No |
| Chemical Dependency  | <input type="radio"/> Yes <input type="radio"/> No | High/Low Blood Pressure | <input type="radio"/> Yes <input type="radio"/> No | Strokes              | <input type="radio"/> Yes <input type="radio"/> No |
| Circulation Problems | <input type="radio"/> Yes <input type="radio"/> No | HIV/AIDS                | <input type="radio"/> Yes <input type="radio"/> No | Thyroid Disease      | <input type="radio"/> Yes <input type="radio"/> No |
| Currently Pregnant   | <input type="radio"/> Yes <input type="radio"/> No | Incontinence            | <input type="radio"/> Yes <input type="radio"/> No | Tuberculosis         | <input type="radio"/> Yes <input type="radio"/> No |
| Depression           | <input type="radio"/> Yes <input type="radio"/> No | Kidney Problems         | <input type="radio"/> Yes <input type="radio"/> No | Vision Problems      | <input type="radio"/> Yes <input type="radio"/> No |
| Diabetes             | <input type="radio"/> Yes <input type="radio"/> No | Metal Implants          | <input type="radio"/> Yes <input type="radio"/> No | Other: _____         | <input type="radio"/> Yes <input type="radio"/> No |

**Surgical History**

Body Region: \_\_\_\_\_ Surgery Type: \_\_\_\_\_ Date: \_\_\_\_\_

Body Region: \_\_\_\_\_ Surgery Type: \_\_\_\_\_ Date: \_\_\_\_\_

**Current Medications**

Drug: \_\_\_\_\_ Dosage: \_\_\_\_\_ Frequency: \_\_\_\_\_ Route: \_\_\_\_\_ Reason Taking: \_\_\_\_\_

Drug: \_\_\_\_\_ Dosage: \_\_\_\_\_ Frequency: \_\_\_\_\_ Route: \_\_\_\_\_ Reason Taking: \_\_\_\_\_

Drug: \_\_\_\_\_ Dosage: \_\_\_\_\_ Frequency: \_\_\_\_\_ Route: \_\_\_\_\_ Reason Taking: \_\_\_\_\_

Drug: \_\_\_\_\_ Dosage: \_\_\_\_\_ Frequency: \_\_\_\_\_ Route: \_\_\_\_\_ Reason Taking: \_\_\_\_\_

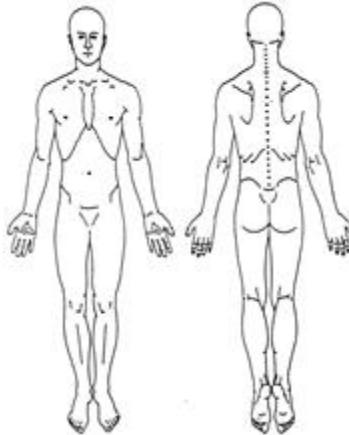
**Fall History**

Injury as a result of a fall in the past year?  Yes  No

Two or more falls in the past year?  Yes  No



Please draw the location of your pain below.



| Pain and Symptoms  |   |
|--|---|
| Nausea: <input type="radio"/> Yes <input type="radio"/> No   | Dizziness: <input type="radio"/> Yes <input type="radio"/> No |
| What makes your symptoms worse?  |   |
| What makes your symptoms better?   |   |
| Does your pain disrupt your ability to sleep? <input type="radio"/> Yes <input type="radio"/> No   |   |
| Before your pain began, were you free of all symptoms? If no please explain:   |   |
| What other treatment are you receiving?  |   |
| Have you had any diagnostic testing? <input type="radio"/> None <input type="radio"/> X-Rays <input type="radio"/> MRI <input type="radio"/> CAT <input type="radio"/> EMG <input type="radio"/> Other |   |

| Description of Pain  |
|--|
| Please check any that apply: <input type="radio"/> Dull <input type="radio"/> Sharp <input type="radio"/> Achy <input type="radio"/> Numb <input type="radio"/> Tingling |
| Pain Rating (0=No pain, 10=Excruciating pain) Today: _____ At best: _____ At worst: _____  |
| Numbness or Tingling: <input type="radio"/> Yes <input type="radio"/> No Location: _____   |

| Females  |
|--|
| I am or may be pregnant <input type="radio"/> Yes <input type="radio"/> No |
| Date of last breast exam: _____ Date of last pelvic exam: _____            |
| Males  |
| Date of last prostate exam: _____  |
| List exercise program or activities performed before your injury:          |
| Please list your goals for Physical Therapy:                               |

I certify that the above information is correct to the best of my knowledge. I will not hold my physical therapist or any members of the staff responsible for any errors that I have made in completing this form. I authorize Wellspring Physical Therapy to provide prescribed treatment based on my evaluation.

Patient Signature \_\_\_\_\_ Date: \_\_\_\_\_

Physical Therapist Signature \_\_\_\_\_