TOTAL PERFORMANCE PHYSICAL THERAPY
Stronger. Faster. Better.

Patient Intake Form

Patient Information			
Name:			
Address:			
City:	State:	Zip Code:	
SSN#	Email:		
Home Phone: ( ) -	Work Phone: ( ) -	Cell Phone: ( ) -	
Date of Birth: / /	Age:	Sex:	Weight:
Marital Status: ☐ Single ☐ Divorced ☐ Widowed ☐ Married – Partner's Name: _____			
Work Information			
Employer/Business:			
Occupation:			
Address of employer:			
City:	State:	Zip Code:	
Medical Team Information			
Referring Doctor:	Phone: ( ) -		
Primary Care Doctor:	Phone: ( ) -		
Insurance Information			
Primary Insurance Name:			
Subscribers Name:			
Date of Birth: / /	ID #	Group/policy #	
Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other			
Name of secondary insurance:			
Subscribers Name:			
Date of Birth: / /	ID #	Group/policy #	
Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other			
Attorney Information			
Name:			
Address:			
City:	State:	Zip Code:	

Worker's Compensation and Auto Insurance		
Date of accident: / /	Adjuster/case manager name:	Phone: ( ) -
Injured body part:		
Address:		
City:	State:	Zip Code:
Claim #		
Cause:		
Prior Medical Care		
Have you had any therapy (PT/OT/Speech) visits this year? ☐ Yes ☐ No		If so, how many? _____
Have you had any chiropractic visits this year? ☐ Yes ☐ No		If so, how many? _____
How did you hear about us?		
☐ Doctor referred me ☐ Website ☐ Search engine ☐ List provided by doctor ☐ Insurance list ☐ Mailing ☐ Former patient ☐ Friend/family their name: _____ ☐ Street sign ☐ Other: _____		
Emergency Contact Information		
Name:		
Home Phone: ( ) -	Work Phone: ( ) -	Cell Phone: ( ) -
Relationship to patient:		

Patient Medical History

Condition	Self		Family	
Arthritis	☐ Yes	☐ No	☐ Yes	☐ No
Rheumatoid Arthritis	☐ Yes	☐ No	☐ Yes	☐ No
Back problems	☐ Yes	☐ No	☐ Yes	☐ No
Neck problems	☐ Yes	☐ No	☐ Yes	☐ No
Headaches	☐ Yes	☐ No	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	☐ Yes	☐ No
Depression	☐ Yes	☐ No	☐ Yes	☐ No
High blood pressure	☐ Yes	☐ No	☐ Yes	☐ No
Heart disease	☐ Yes	☐ No	☐ Yes	☐ No
Incontinence	☐ Yes	☐ No	☐ Yes	☐ No
Seizures/Epilepsy	☐ Yes	☐ No	☐ Yes	☐ No
Pacemaker	☐ Yes	☐ No	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	☐ Yes	☐ No
Stroke	☐ Yes	☐ No	☐ Yes	☐ No
Metal implants	☐ Yes	☐ No	☐ Yes	☐ No
Heart attack	☐ Yes	☐ No	☐ Yes	☐ No
Shoulder problems	☐ Yes	☐ No	☐ Yes	☐ No
Knee problems	☐ Yes	☐ No	☐ Yes	☐ No
Hip problems	☐ Yes	☐ No	☐ Yes	☐ No
Ankle problems	☐ Yes	☐ No	☐ Yes	☐ No
Foot problems	☐ Yes	☐ No	☐ Yes	☐ No
Weakness	☐ Yes	☐ No	☐ Yes	☐ No
Dizziness	☐ Yes	☐ No	☐ Yes	☐ No
Balance problems	☐ Yes	☐ No	☐ Yes	☐ No
Muscular dystrophy	☐ Yes	☐ No	☐ Yes	☐ No
Multiple sclerosis	☐ Yes	☐ No	☐ Yes	☐ No
Fibromyalgia	☐ Yes	☐ No	☐ Yes	☐ No
Hearing loss	☐ Yes	☐ No	☐ Yes	☐ No
Poor eye sight	☐ Yes	☐ No	☐ Yes	☐ No
Fainting	☐ Yes	☐ No	☐ Yes	☐ No

Please answer yes or no to the following questions below. If you check yes, please provide dates and pertinent details.

Are you pregnant?	☐ Yes	☐ No	How many weeks? _____
Do you smoke?	☐ Yes	☐ No	How many packs? _____
Did you have surgery?	☐ Yes	☐ No	Details: _____
			_____
Do you experience frequent nausea/vomiting?	☐ Yes	☐ No	Details: _____
			_____
Have you had unexplained weight loss?	☐ Yes	☐ No	Details: _____
Do you have numbness/tingling?	☐ Yes	☐ No	Details: _____
			_____
Do you experience night pain?	☐ Yes	☐ No	Details: _____
			_____
Have you had any changes in bowel or bladder?	☐ Yes	☐ No	Details: _____

Describe the nature of your injury/condition: _____

_____

List all current medications: _____

_____

List results of any diagnostic tests (xrays, MRI, EMGs, etc): _____

_____

_____ _____

Signature of Patient, Parent, Guardian Date