SPORTS AND BACK REHABILITATION

Patient Intake Form

First Name: _____ MI: _____ Last Name: _____

Social Security Number: _____ Date of Birth: _____

Date of Injury: _____ Gender: ☐ Male ☐ Female

Mailing Address: _____

Physical Address: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Domestic Partner

Employment Status: ☐ Full-Time ☐ Part-Time ☐ Self Employed ☐ Active Duty ☐ Disabled
☐ Retired ☐ Student ☐ Not Working

Patient's Employer _____ Occupation: _____
Employer's Address _____
Employer's Phone Number: _____

Spouse's Employer _____ Occupation: _____
Employer's Address _____
Employer's Phone Number: _____

Primary Spoken Language: _____ ☐ Interpreter Required

Attorney's Name: _____ Phone Number: _____
Address _____

Emergency Contact: _____ Phone Number: _____
Relationship _____

Prescribing Physician: _____ Phone Number: _____
Do you have a written prescription? ☐ Yes ☐ No
Is this a chronic condition? ☐ Yes ☐ No

Was this injury the result of an accident? ☐ Work ☐ Auto ☐ Other ☐ None

Were you hospitalized for this injury? ☐ Yes, How long? _____ ☐ No

How did you hear about Sports and Back Rehabilitation? ☐ Physician ☐ Self

☐ Marketing Ad - (Circle all that apply) - Print – Facebook – Newsletter – Email – Website

☐ Former Patient ☐ Case Manager ☐ Employer ☐ Adjustor ☐ Internet Search

☐ Word of Mouth ☐ Other: _____

What is the name of the insurance company that will be paying for your therapy? _____

Address: _____

Phone Number: _____ ID/Claim Number: _____

Adjustor (Auto/Work Comp): _____

Name of the person that carries the insurance? _____

☐ If Self, please move on to the next section.

Address: _____

Phone Number: _____ Date of Birth: _____

Social Security Number of Insured: _____ Relationship: _____

Employer's Name and Address: _____

Privacy Statement

We know that privacy is important to you and Sports and Back Rehabilitation is committed to protecting yours. Your privacy is a priority to us. We will not share information about you to anyone other than your doctors, your insurance company and your attorney, if applicable. **Please advise us if there is anyone you would not want us to give information.** We would also share pertinent information with the credit bureau only if you have an outstanding balance that is your responsibility (not the insurance company's) and you do not respond to our invoices.

We treat most patients in an open gym setting, to give all our patients the best possible care, time and attention. If you prefer not to be in the open gym for your treatment session, we do have curtained areas that can be used but you must make the therapist aware of your preference. Also if you have a private issue to discuss with your physical therapist regarding your care, please let them know and they will make the necessary arrangements.

Our physical therapists and staff will make every effort to protect your privacy and if you feel this is not the case, please contact the office at any time.

Patient Signature and Date

_____

General Questionnaire

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Patient Name: _____ Age: _____

Today's Date: _____ Date of Birth: _____

Height: _____ Weight: _____ Hand Dominance: ☐ Left ☐ Right

Why are you seeking skilled PT services? _____

When/How did you get hurt? _____

Have you had this problem before? ☐ No ☐ Yes, When? _____

When did you last see your physician regarding this problem? _____

Have you had recent surgery for this condition? ☐ No ☐ Yes, Date/Type _____

Chief Complaints ☐ No Difficulty

☐ Awakened by pain ☐ Loss of motion – stiffness

☐ Swelling ☐ Difficulty walking ☐ Loss of function ☐ Weakness

Pain ☐ No (Skip this section) ☐ Yes, Location _____

Current Pain Level on a 0 to 10 Scale (0= No pain, 5= Strong, 10 = Worst imaginable pain) _____/10

Lowest Pain Level (0 to 10 Scale): _____/10

Highest Pain Level (0 to 10 Scale): _____/10

How frequent is your pain? ☐ Constant ☐ Intermittent

When is the pain the greatest? ☐ Morning ☐ Afternoon ☐ Night ☐ No specific timeline

When is your pain most present? _____

What provides pain relief? _____

Description of pain: ☐ Dull ☐ Shooting ☐ Aching ☐ Throbbing ☐ Radiating ☐ Numb

☐ Tingling ☐ Miserable ☐ Burning ☐ Stabbing ☐ Other: _____

Functional Status

What activities have you find to be more difficult since your symptoms began? _____

_____

Prior to your onset of symptoms, how much of **your daily activities** were you able to perform?

☐_____% How about now? _____%

Work

Have you been out of work due to this injury? ☐ Yes ☐ No How Long? _____

What are some tasks you are expected to do at work? _____

What are you goals for physical therapy? _____

Social History

Current Smoker: YES / NO Packs/Day _____ Years Smoking _____

Previous Smoker: YES / NO Years Smoke Free_____ Years Smoked _____

Living Situation: ☐ Alone ☐ Family ☐ Roommate # of Steps to Enter Home _____

# of Steps to Bedroom/Bathroom _____

Hospitalization (Check all that apply Since January 1st)

☐ Recent Hospitalization ☐ Skilled Nursing Care ☐ Home Health Care ☐ Outpatient Therapy

Medical History

Do you have or use any of the following? (Check all that apply) ☐Hearing Aid ☐ Eye Glasses

☐ Walker ☐ W/C ☐ Cane ☐ Brace ☐ Other: _____

Previous Surgeries: List any previous surgeries with dates _____

_____

Recent Diagnostic Tests: ☐ X-ray ☐ MRI ☐ EMG ☐ CT Scan ☐ NCV ☐ Bone Scan ☐ Other:

Results: _____

Specialists: Which specialists do you currently see?

☐ Allergist ☐ Audiologist ☐ Cardiologist ☐ Chiropractor ☐ Endocrinologist

☐ Hand Surgeon ☐ Nephrologists ☐ Neurologist ☐ Oncologist ☐ Orthopedic

☐ Podiatrist ☐ Psychiatrist ☐ Rheumatologist ☐ Other: _____

Medications (Check all that apply)

☐ Acetaminophen ☐ Antibiotics ☐ Antidepressants ☐ Cancer ☐ Cardiac

☐ Cholesterol ☐ Diabetic ☐ High Blood Pressure ☐ Ibuprofen ☐ Muscle Relaxant

☐ NSAIDs ☐ Osteoporosis Meds ☐ Pain Meds ☐ Steroids

☐ Other: _____

Conditions: Please Check All that Apply

☐ Anemia ☐ Arthritis ☐ Asthma ☐ Bipolar Disorder ☐ Bleeding Condition ☐ Blindness

☐ Cataracts ☐ Cancer ☐ High cholesterol ☐ Chronic Pain ☐ Chronic Venastasis ☐Gout

☐ Cracked Ribs ☐ Disc Disease ☐ Depression ☐ Diabetes ☐ Dizziness ☐ Epilepsy

☐ Endurance Limitations ☐Emphysema ☐ Eyesight Issues ☐ Falls ☐ Heart Condition

☐ Hallucinations ☐ Headaches ☐ Hearing Problems ☐ Hepatitis A ☐ Hep B ☐Hep C

☐Hernia ☐Hypertension ☐ Hypotension ☐Infectious Diseases ☐ Joint Replacement

☐ Kidney Disease ☐ Liver Disease ☐ Fatigue ☐ MRSA infection ☐ Fractures/Tears

☐ Mental/Cognitive Issue ☐ Metal Implants ☐ Muscle Weakness ☐ Nausea/Vomiting

☐ Osteoarthritis ☐ Osteoporosis ☐ Pacemaker ☐ Pancreatitis ☐ Pregnancy

☐ Respiratory Issues ☐ Rheumatoid Arthritis ☐ Shortness of Breath ☐ Stroke

☐ Substance Abuse ☐ UTI ☐ Syncope/Fainting ☐ Thyroid Condition ☐ Weight Change

☐ Other: _____

Instructions for Care

Is there anything regarding your condition or treatment we should be aware of? ☐ No

☐ Yes, Please Explain _____

Are there any contraindications for care or religious beliefs that we should be aware of? ☐ No

☐ Yes, Please Explain _____

Are there any specific instructions given to you by the doctor? No ☐ Yes, Please Explain

_____

PLEASE GIVE THIS PACKET TO THE SECRETARY PRIOR TO COMPLETING THE REMAINING PAPERWORK. Thank you!