New Client Intake Form (Adult – General/Ortho)

Client Information:

Patient First Name: _____ Patient Last Name: _____ DOB: _____

Address: _____ City/State: _____ Zip Code: _____

Phone: _____ Secondary Phone: _____ Email: _____

Emergency Contact Name: _____ Emergency Contact Phone: _____

Referring Provider: _____ Referring Provider Phone: _____

Do you authorize us to contact your physician to share patient health information/medical records? Yes ____ No ____

How did you hear about us? _____

Primary Concerns/Pain:

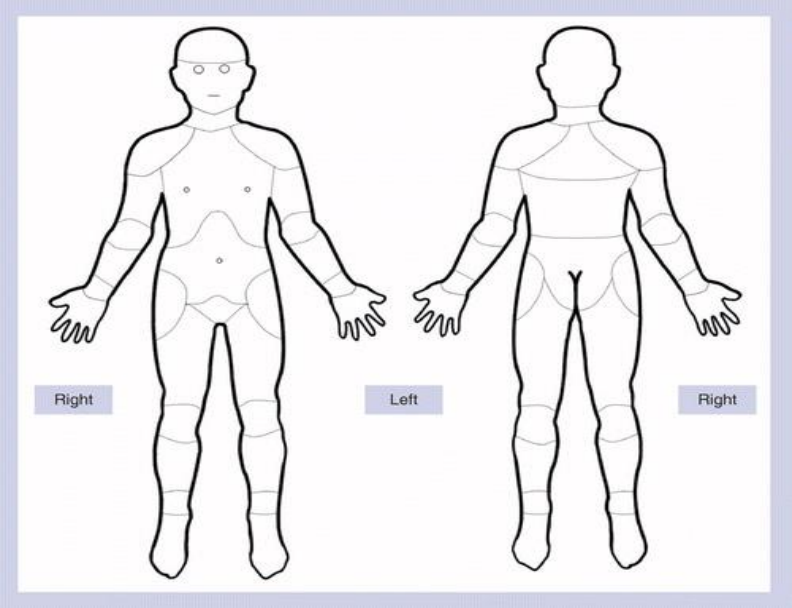
Please describe your primary complaint or reason for seeking physical therapy.

_____

_____

Are you currently experiencing pain? Yes ____ No ____ Approximately how long have you had pain? _____

Please mark the diagram in locations corresponding with your pain or symptoms.



Choose any of the following to describe your pain:

- ☐ Aching
- ☐ Cramping
- ☐ Numbness/Tingling
- ☐ Intermittent
- ☐ Burning
- ☐ Dull
- ☐ Sharp/Stabbing
- ☐ Throbbing

Does pain interrupt your sleep?

Yes ____ No ____

Rate the severity of your pain or discomfort, using a 0-10 scale. (0 = no pain, 10 = severe pain)

1 2 3 4 5 6 7 8 9 10

Fit Family Physical Therapy, LLC
Phone: (480)788-0046
Fax: (480) 771-3415

What activities or treatments make your pain worse:

_____

What activities or treatments improve or relieve your pain:

_____

Have you attempted any of the following treatments to relieve your pain in the past? (Check all that apply):

- ☐ Massage
- ☐ Ice/Heat
- ☐ Surgery
- ☐ Medications
- ☐ Chiropractic care
- ☐ Physical Therapy
- ☐ Injections
- ☐ Rest

Past Medical History:

Medical History (Check all that apply):

- ☐ High blood pressure
- ☐ Cancer
- ☐ Heart/Coronary disease
- ☐ Rheumatoid Arthritis
- ☐ Diabetes
- ☐ Hernia
- ☐ Stroke/CVA
- ☐ Dizziness/fainting
- ☐ Tobacco use
- ☐ Currently pregnant
- ☐ Seizures
- ☐ Allergies
- ☐ Headaches
- ☐ Neurological disorders
- ☐ Asthma/breathing difficulty
- ☐ Osteoporosis/penia
- ☐ Recent fracture
- ☐ Pacemaker
- ☐ Bowel/bladder dysfunction
- ☐ Prior surgeries

Please list any other present or chronic medical conditions you have:

_____

_____

Please list any prior surgeries/dates:

_____

_____

Known allergies: _____

Medications: _____

Lifestyle/Activity Goals:

Rate your CURRENT level of activity, using a 0-5 scale. (0 = bedridden, 5 = very active)

1 2 3 4 5

If applicable, rate your activity level PRIOR to this injury or onset of pain, using a 0-5 scale. (0 = bedridden, 5 = very active)

1 2 3 4 5

List your primary goals for your physical therapy treatment:

_____

_____

I understand it is up to me to inform the physical therapist/staff about health conditions or allergies that I may have. I certify that the information I have filled out is correct and complete to the best of my knowledge. I must also inform the physical therapist/staff about any medications/supplements that I am taking. I hereby agree and give consent for Fit Family Physical Therapy to evaluate and furnish care that is considered necessary in the diagnosing or treating of my physical condition.

Patient Signature: _____ **Date:** _____

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