ELEVATE
PHYSICAL THERAPY
FITNESS AND PERFORMANCE

2312 South Sixth Street Suite B
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PATIENT INTAKE AND DEMOGRAPHIC INFORMATION

_____ _____
FULL LEGAL NAME PREFERRED NAME

DATE OF BIRTH_____GENDER_____SOC. SEC. #_____

ADDRESS_____CITY_____STATE_____ZIP_____

PRIMARY PHONE #_____ SECONDARY PHONE #_____

E-MAIL ADDRESS_____ MARITAL STATUS_____

Can we leave a voicemail at this number(s)? YES _____ NO_____ Upon completion of your care, can we contact you at the phone or email above to request feedback? YES _____ NO_____

OCCUPATION_____EMPLOYER_____

WORK ADDRESS_____CITY_____STATE_____ZIP_____

PRIMARY CARE PHYSICIAN_____PCP PHONE_____

DIAGNOSIS (IF KNOWN)_____

EMERGENCY DATA

IN CASE OF EMERGENCY CONTACT:

NAME_____ PHONE NUMBER_____

RELATIONSHIP_____ (IF THIS PERSON IS NOT LOCAL, PLEASE LIST AN ADDITIONAL LOCAL CONTACT)

*HOW DID YOU HEAR ABOUT US?*_____

ARE YOU INTERESTED IN STRENGTH TRAINING FOR AFTER YOU COMPLETE YOUR PT?

____*YES!* ___*NO* ___*MAYBE*

ARE YOU INTERESTED IN OUR FITNESS OR PERFORMANCE SERVICES?

____*YES!* ___*NO* ___*MAYBE*

PRIMARY HEALTH INSURANCE INFORMATION

INSURANCE NAME _____ SUBSCRIBER NAME _____

SUBSCRIBER BIRTH DATE ___ / ___ / _____ PATIENT RELATIONSHIP TO SUBSCRIBER _____

SUBSCRIBER ADDRESS _____
STREET CITY ST ZIP

ID NUMBER _____

SECONDARY HEALTH INSURANCE INFORMATION

INSURANCE NAME _____ SUBSCRIBER NAME _____

SUBSCRIBER BIRTH DATE ___ / ___ / _____ PATIENT RELATIONSHIP TO SUBSCRIBER _____

SUBSCRIBER ADDRESS _____
STREET CITY ST ZIP

ID NUMBER _____

MVA OR WORK COMP CLAIM INFORMATION

CLAIM NUMBER_____ INSURED NAME_____

INSURANCE COMPANY NAME _____

CLAIMS ADJUSTER _____ PHONE NUMBER_____

ATTORNEY NAME AND TELEPHONE NUMBER _____

MEDICAL HISTORY FORM

Name:_____ Date of Birth:_____

Height_____ Weight_____

Why are you seeing the physical therapist? (Chief Complaint) _____

_____

Current problem is a result of (Check all that apply): Surgery_____ (Date of surgery_____) Injury_____

Work Accident_____ Car Accident_____ Other_____

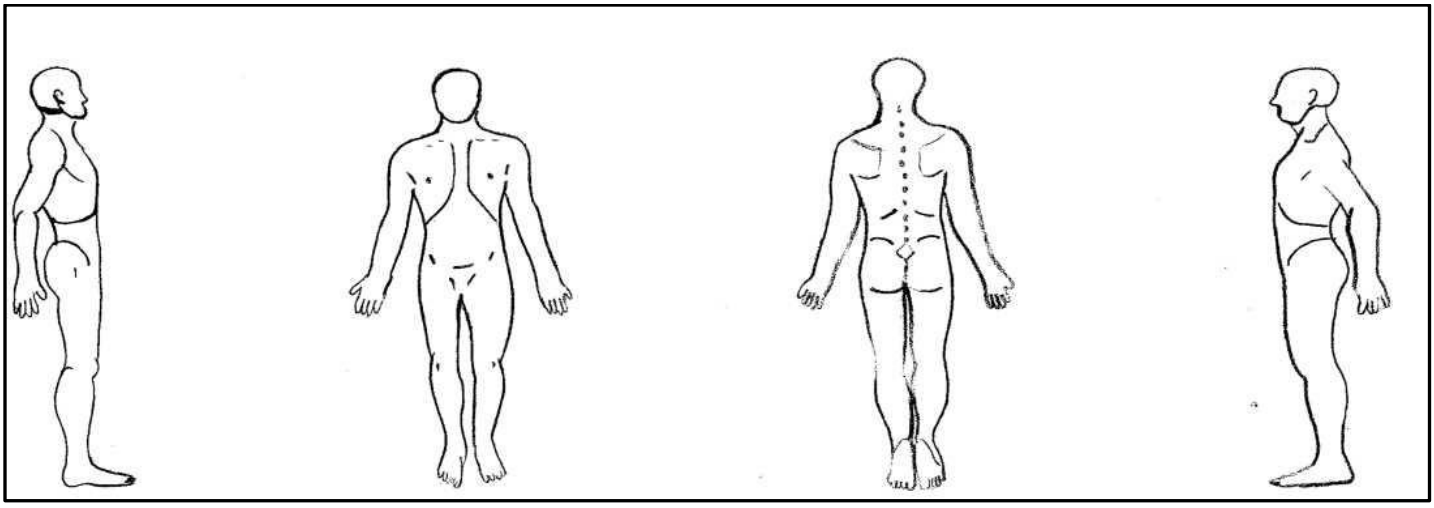
Rate your pain: (0=none, 10=worst) Best (0-10) _____ Worst (0-10) _____ Current (0-10)_____

Location of injury/surgery if applicable: Right_____ Left_____

Indicate the nature of your symptoms (Check all that apply): Sharp____ Dull____ Piercing____ Shooting____

Aching____ Deep____ Superficial____ Tingling____ Numbness____ Intermittent____ Burning____ Stabbing____

Where is your problem? Indicate on the body chart Pain: “xxx” Numbness: “ooo” Tingling: “zzz”



When and how did this problem begin?_____

What makes your symptom(s)/pain(s) worse?_____

What makes your symptom(s)/pain(s) better?_____

Are your symptoms worse in the: Morning_____ Afternoon_____ Evening_____ Inconsistent_____

Are your symptoms: Improving_____ Worse_____ Stable_____

Has this problem affected your daily life/routine? How? _____

_____

Have you had similar episodes of this current problem in the past? (If yes, circle disciplines, which apply) Physical Therapy, Acupuncture, M.D. (Meds, TPI's) Massage Therapist, Chiropractor, Pilates, General Exercise, exercise with trainer, Self-Medicated (Advil), ignored it, other. Did they help to alleviate your symptoms? _____

Have you undergone any special tests for this condition? (X-rays, MRI's, ETC) If yes, do you know the results? _____

_____

Please answer the following questions:

	Yes	*No*
1) Do the current problems interrupt your sleep?		
2) Do your symptoms change with coughing or sneezing?		
3) Have you had any recent changes in bowel or bladder function?		
4) Do you experience any dizziness or vertigo?		
5) Have you had any recent change in your weight or appetite?		
6) Do you have any intolerance to hot or cold?		
7) Do you have any bruising or bleeding disorders?		
8) Have you had any skin changes, such as rashes or discoloration?		
9) Have you experienced any changes in your vision, such as blurring, double vision, or decrease in your visual fields?		
10) Have you had a recent episode of nausea/vomiting?		
11) Are you pregnant?		
12) Do you have osteoporosis? Date of your last bone scan:		
13) Do you have any allergies? (please list)		
14) Have you noticed any shortness of breath or decrease in exercise tolerance?		
15) Do you use any assistive devise? (e.g., cane, foot orthotics)		
16) Do you have high blood pressure?		
17) Do you have any cardiac problems?		
18) Do you have diabetes?		
19) Have you ever had cancer of any sort? (If yes, type?)		
20) Do you have a history of neck or back problems?		
21) Have you fallen recently? If so, how many times in the past year?		
22) Do you smoke? If yes, how much/often?		
23) Do you drink alcohol? If yes, how much/often?		
24) Do you exercise regularly? If yes, what kind and how often?		

Please list any medications you are currently taking. (We will take a copy of a list if you have one instead):

_____

Does anyone in your immediate family have a history of diabetes, high blood pressure, cardiac issues or cancer?

_____