ELEVATE
PHYSICAL THERAPY

Patient Intake Form

PATIENT NAME: _____

DATE OF BIRTH:_____AGE:_____SOCIAL SECURITY #:_____

GENDER: ☐ MALE ☐ FEMALE **MARITIAL STATUS**: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

PHONE #:_____SECONDARY #:_____

ADDRESS:_____

CITY:_____STATE:_____ZIP CODE:_____

EMAIL:_____OCCUPATION:_____

EMPLOYER:_____EMPLOYER PHONE #:_____

EMERGENCY CONTACT:_____RELATIONOSHIP:_____

EMERGENCY CONTACT #:_____

INSURANCE COMPANY:_____

CONTRACT #:_____GROUP #:_____

IF OTHER THAN THE PATIENT, PLEASE TELL US ABOUT THE POLICY HOLDER

POLICY HOLDER'S NAME:_____POLICY HOLDER'S DATE OF BIRTH:_____

POLICY HOLDER'S PHONE #:_____RELATIONSHIP TO PATIENT:_____

POLICY HOLDER'S EMPLOYER:_____EMPLOYER'S PHONE #:_____

ADDRESS OF POLICY HOLDER:_____

CITY:_____STATE:_____ZIP CODE:_____

REASON FOR VISIT:_____

FOLLOW UP APPOINTMENT WITH REFERRING PHYSICIAN:_____/_____/_____

HAVE YOU RECEIVED PT, OT, SPEECH, OR CHIROPRACTIC SERVICES THIS YEAR? ☐ YES ☐ NO

ARE WE TREATING A CONDITION AS A RESULT OF AN ACCIDENT? ☐ YES ☐ NO ACCIDENT DATE:____/____/_____

IF YES, WHAT KIND OF ACCIDENT? ☐ AUTO ☐ WORKER'S COMPENSATION ☐ OTHER

BREIFLY DESCRIBE THE ACCIDENT:_____

MEDICAL HISTORY INFORMATION

DO YOU HAVE ALLERGIES TO LATEX, METALS, MEDICATIONS, OR ADHESIVES? ☐ YES ☐ NO

IF YES, PLEASE DESCRIBE:_____

DO YOU HAVE/HAD ANY OF THE FOLLOWING CONDITIONS?

	HIGH BLOOD PRESSURE		AUTOIMMUNE DISORDER		HEADACHES/MIGRAINES		DEMENTIA
	DIABETES		KIDNEY DISEASE		NIGHT SWEATS		FIBROMYALGIA
	HISTORY OF CANCER		HIV/HEP B/HEP C		SYNCOPE		TRAUMATIC BRAIN INJURY
	SEIZURES		RECURRING FRACTURES		DIZZINESS		RHEUMATOID ARTHRITIS
	HEART TROUBLE		OSTEOPOROSIS		NUMBNESS/TINGLING		OTHER:

DO YOU HAVE A PACEMAKER OR DEFIBULATOR? ☐ YES ☐ NO

DO YOU HAVE A INTERNAL OR SPINAL STIMULATOR? ☐ YES ☐ NO

PAST SURGERIES

1.	4.	7.
2.	5.	8.
3.	6.	9.

LIST OF CURRENT MEDICATIONS:

1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

ARE YOU CURRENTLY PREGNANT? ☐ YES ☐ NO

HOW DID YOU HEAR ABOUT US?_____

IS THERE SOMEONE WE MAY THANK FOR REFERRING YOU TO US?_____

PATIENT SIGNATURE:

X_____DATE:_____