Clear form

Patient Intake

Patient Information

Date: _____

First Last Name: _____

Date of Birth: _____

Sex: ☐ Male ☐ Female

Phone: _____

Address:_____

Emergency contact/ number: _____

How did you hear about us?: _____

About Your Pain/ Injury/ Condition

Describe your injury/ pain: _____

_____

When did it start? (Date of surgery if applicable): _____

What makes it worse?: _____

What alleviates your symptoms?: _____

Is your pain constant or intermittent: ◯ CONSTANT ◯ INTERMITTENT ◯ Other:

On a scale of 0-10 what is your pain at its worst?:

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

On a scale of 0-10 what is your pain at it's best?:

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

What is your pain on average?:

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

What testing/ imaging have you undergone for this injury? (X-ray), MRI, CT scan, EMG) :

Medical History

Check yes or no if you have/ had the following:	Yes	No
High blood pressure/ hypertension:	◯	◯
Fever and Chills:	◯	◯
COPD/ asthma:	◯	◯
Open wounds:	◯	◯
Joint replacement:	◯	◯
Currently/ maybe pregnant:	◯	◯
Head/ neck injury:	◯	◯
Vascular problem:	◯	◯
Osteoporosis/ osteopenia:	◯	◯
Seizures/ epilepsy:	◯	◯
Rheumatoid arthritis:	◯	◯

Osteoarthritis:	◯	◯
Infectious disease:	◯	◯
Stroke/ TIA:	◯	◯
Cancer:	◯	◯
Concussion:	◯	◯
Fracture:	◯	◯
Heart disease/ pacemaker:	◯	◯
Diabetes:	◯	◯
Unexplained weight loss:	◯	◯

If you marked yes for any of the above, please explain:_____

Allergies: _____

Please list any medications you are currently taking: _____

Please list any surgeries which may affect treatment: _____

What are your goals for Physical therapy?:_____

Informed consent (type full name and date)

I understand that I am receiving physical therapy care at Apex Performance Therapy LLC for evaluation and treatment. This may consist of history taking, movement screening, various tests and measures, and manual therapy, education and exercise. The exercises may consist of stretching, general movements, strengthening and self treatments. The Doctor of Physical Therapy has informed me of any potential risks, advantages of treatments, and alternative options. I can stop evaluation and treatment at anytime, and freely able to ask my therapist questions at any time.

Name:_____

Date:_____

Email: