



PATIENT INTAKE - update

Name _____ Today's Date ____/____/____ Date of Birth ____/____/____
 Address _____ City _____ State _____ Zip _____
 Home Phone(____)____-____ Work Phone(____)____-____ Cell Phone(____)____-____
 E-Mail _____ **Height** ____' ____" **Weight** _____ lbs
If patient is a minor name guardian _____ relationship _____
Emergency contact _____ Phone _____ physician: _____

Current Complaints	Date of Onset	Probable cause

History of Current Complaints None If this is a recurrent problem please describe the **initial cause**, the frequency, how you have treated in the past, and if past treatment was successful:

NONE For the **PRESENTING CONDITION and OTHER CURRENT CONDITIONS** which you are treating, please list **ALL providers, treatments and outcomes**

Recommended by Self / Doctor / therapist	Treatment / Testing PT, exercises, medications, ice, heat, x-ray, MRI, CT, labs	Outcome partial or temp relief, no help, etc.

NONE Please list any other **serious** illnesses or conditions which you have been diagnosed and/or treated (cancer, heart, diabetes, mental, TB, high blood pressure, high cholesterol, HIV, asthma etc.)

Condition	Date diagnosed	Treatment – if hospitalized please write H	Outcome

NONE prescription or over the counter medications AND supplements you are currently taking

Name	Reason	Dosage	Frequency	How long	Side effects

NONE Please list all significant trauma (auto, lifting, fracture, dislocation, sport)

Type of trauma	Date	Body parts injured	Treatment please if hospitalized write H	Residual problems

