Patient Intake

Patient Information		
First:	Middle:	Last:
Gender: ○ Male ○ Female	Social Security:	
Date of Birth:	Marital Status: ○ Single ○ Married ○ Other	
Student Status: ○ Fulltime ○ Part time ○ N/A		
○ Patient Under 18	Parent/Guardian Name:	

Mailing Address		
Street:		
City:	State:	Zip/Postal Code:

Contact	
Email:	
Home Phone:	Mobile Phone:
Preferred Contact Method: ○ Home ○ Mobile Phone	
Emergency Contact	
Contact Name:	
Contact Phone:	
Relationship: ○ Spouse ○ Parent ○ Sibling ○ Guardian ○ Other _____	

Employer		
Name:		
Street:		
City:	State:	Zip/Postal Code:
Phone:		

Who referred you to Wellspring Physical Therapy? _____

Physician that referred you: _____

I hereby authorize Wellspring Physical Therapy to be paid directly by my insurance company for their services. I understand that I am financially responsible for all charges not covered or paid by my insurance. I hereby authorize Wellspring Physical Therapy or my insurance company to release all information necessary to process and secure payment for my claim.

Patient or Guardian Signature: _____ Date: _____

Wellspring Physical Therapy

Patient Information	
Name:	Date:
Height: Weight:	Age:
Are you currently working? ○ Yes ○ No	
Reason for visit:	
Date of injury if known:	
Occupation:	Job Duties:

Medical History

Existing Conditions

Allergies	○ Yes ○ No	Dizzy Spells	○ Yes ○ No	MRSA	○ Yes ○ No
Anemia	○ Yes ○ No	Emphysema/Bronchitis	○ Yes ○ No	Multiple Sclerosis	○ Yes ○ No
Anxiety	○ Yes ○ No	Fibromyalgia	○ Yes ○ No	Muscular Disease	○ Yes ○ No
Arthritis	○ Yes ○ No	Fractures	○ Yes ○ No	Osteoporosis	○ Yes ○ No
Asthma	○ Yes ○ No	Gallbladder Problems	○ Yes ○ No	Parkinsons	○ Yes ○ No
Autoimmune Disorder	○ Yes ○ No	Headaches	○ Yes ○ No	Rheumatoid Arthritis	○ Yes ○ No
Cancer	○ Yes ○ No	Hearing Impairment	○ Yes ○ No	Seizures	○ Yes ○ No
Cardiac Conditions	○ Yes ○ No	Hepatitis	○ Yes ○ No	Smoking	○ Yes ○ No
Cardiac Pacemaker	○ Yes ○ No	High Cholesterol	○ Yes ○ No	Speech Problems	○ Yes ○ No
Chemical Dependency	○ Yes ○ No	High/Low Blood Pressure	○ Yes ○ No	Strokes	○ Yes ○ No
Circulation Problems	○ Yes ○ No	HIV/AIDS	○ Yes ○ No	Thyroid Disease	○ Yes ○ No
Currently Pregnant	○ Yes ○ No	Incontinence	○ Yes ○ No	Tuberculosis	○ Yes ○ No
Depression	○ Yes ○ No	Kidney Problems	○ Yes ○ No	Vision Problems	○ Yes ○ No
Diabetes	○ Yes ○ No	Metal Implants	○ Yes ○ No	Other:_____	○ Yes ○ No

Surgical History

Body Region: _____ Surgery Type: _____ Date: _____

Body Region: _____ Surgery Type: _____ Date: _____

Current Medications

Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason Taking: _____

Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason Taking: _____

Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason Taking: _____

Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason Taking: _____

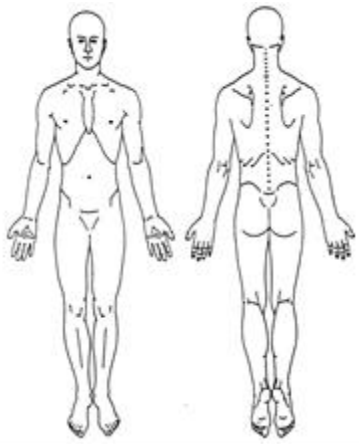
Fall History

Injury as a result of a fall in the past year? ○ Yes ○ No

Two or more falls in the past year? ○ Yes ○ No

Wellspring Physical Therapy

Please draw the location of your pain below.



Pain and Symptoms	
Nausea: ○ Yes ○ No	Dizziness: ○ Yes ○ No
What makes your symptoms worse?	
What makes your symptoms better?	
Does your pain disrupt your ability to sleep? ○ Yes ○ No	
Before your pain began, were you free of all symptoms? If no please explain:	
What other treatment are you receiving?	
Have you had any diagnostic testing? ○ None ○ X-Rays ○ MRI ○ CAT ○ EMG ○ Other	

Description of Pain
Please check any that apply: ○ Dull ○ Sharp ○ Achy ○ Numb ○ Tingling
Pain Rating *(0=No pain, 10=Excruciating pain)* Today:_____ At best:_____ At worst:_____
Numbness or Tingling: ○ Yes ○ No Location:

Females	
I am or may be pregnant ○ Yes ○ No	
Date of last breast exam:	Date of last pelvic exam:
Males	
Date of last prostate exam:	
List exercise program or activities performed before your injury:	
Please list your goals for Physical Therapy:	

I certify that the above information is correct to the best of my knowledge. I will not hold my physical therapist or any members of the staff responsible for any errors that I have made in completing this form. I authorize Wellspring Physical Therapy to provide prescribed treatment based on my evaluation.

Patient Signature _____ Date: _____

Physical Therapist Signature _____