Intake Form

Patient Information

Name_____

Male_____ **Female**_____

Street Address_____ **City**_____**State**___ **Zip**_____

Date of Birth____/_____/_____

Home Phone_____ **Alternate Phone**_____

Email:_____

Employer Name:_____

Emergency contact Name:_____**Phone number:**_____

Physician Information

Primary Care Physician Name:_____

PCP Address:_____

PCP Phone #:_____

Name of Specialist or other Physicians involved in current care:_____

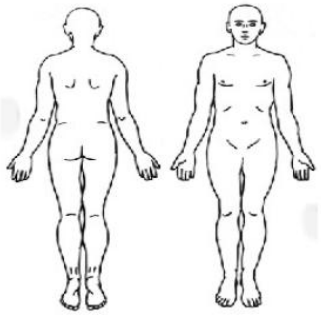
_____

How did you learn about the rehabilitation services provided by Balance Physical Therapy, LLC? (Please check all that apply)

- ☐ Physician
- ☐ Employer
- ☐ Personal trainer
- ☐ Recommendation from Friend/ Family Member
- ☐ Flyer
- ☐ Newspaper/magazine ad
- ☐ Prior experience with Balance Physical Therapy, LLC
- ☐ Other (please specify)_____

Health Information:

Please note areas of pain on the body chart below:



Today's Date: _____ **Date of Injury/onset:** _____
Have you ever had these symptoms before (circle): Yes / No If so, when: _____

The following is a list of common health problems. In the first column please indicate if you currently or have ever had any of the problems in the past. In the second column please comment on any current/past treatment, or impact on daily living.

	Do you or have you had the problem? Y	N	Comments; current/past treatment, etc
Heart Disease	□	□	_____
Do you have a pacemaker	□	□	_____
Heart Attack	□	□	_____
High Blood Pressure	□	□	_____
Low Blood Pressure	□	□	_____
Lung Disease/Asthma	□	□	_____
Diabetes	□	□	_____
Ulcer or Stomach Disease	□	□	_____
Nausea/Vomiting	□	□	_____
Hernia	□	□	_____
Kidney Problem	□	□	_____
Liver/Gall Bladder problems	□	□	_____
Drug or alcohol use	□	□	_____
Anemia or blood condition	□	□	_____
Ringing in the ears	□	□	_____
Cancer	□	□	_____
Sexual dysfunction	□	□	_____
Anxiey/Depression	□	□	_____
Seizures	□	□	_____
Fainting/Headache	□	□	_____
Dizziness/Vertigo	□	□	_____
Nerve disease/disorder	□	□	_____
Muscle disease/disorder	□	□	_____
Immune disease/disorder	□	□	_____
Hearing loss	□	□	_____
Vision loss	□	□	_____
Arthritis	□	□	_____
Allergies	□	□	_____
Skin Disorder	□	□	_____
Are you pregnant?	□	□	_____
Smoking/Tobacco use	□	□	_____
Bowel/Bladder irregularities	□	□	_____
Menstrual irregularities	□	□	_____
Stroke	□	□	_____
Osteoporosis	□	□	_____
Numbness or tingling	□	□	_____
Shortness of breath	□	□	_____
Recent unexplained weight loss or gain	□	□	_____
Recent fever, chills, malaise	□	□	_____
Are you currently taking steroids or have a history of long-term steroid use?	□	□	_____

Surgeries with corresponding dates: _____
_____

Current Medications and reasons for taking: _____
_____

Signature: _____ Date: _____
Relationship to patient: _____
Thank you!