



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

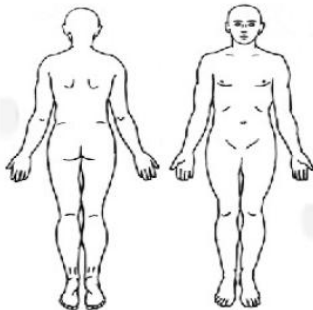
Primary Care Physician Name: _____
PCP Address: _____
PCP Phone #: _____
Name of Specialist or other Physicians involved in current care: _____

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

Surgeries with corresponding dates: _____

Current Medications and reasons for taking: _____

Signature: _____ Date: _____

Relationship to patient: _____

Thank you!