PATIENT INTAKE

Name:_____ **Age:**_____**Date:**_____

Primary Care Doctor: _____**Next Doctor's Appt:** _____

Reason for your Visit:_____

Injury: Yes / No **Currently Working:** Yes / No **Occupation:**_____

***Note:** If third party liability injury, you may be responsible for charges; subject to your Insurance policy

Diagnostic Testing Done: (please circle) NONE / X-Ray / MRI / CT / Other_____

Previous Treatments: NONE / Wound Care/ Physical Therapy / Chiropractor / Injections / Other:

(Please list)_____

Chronic Health Problems:_____

Medications:_____

Medication Allergies: Yes / No If yes, please list_____

Special Needs: (circle) NONE / Vision/ Hearing / Speech/ Language / Cultural / Religious / Other

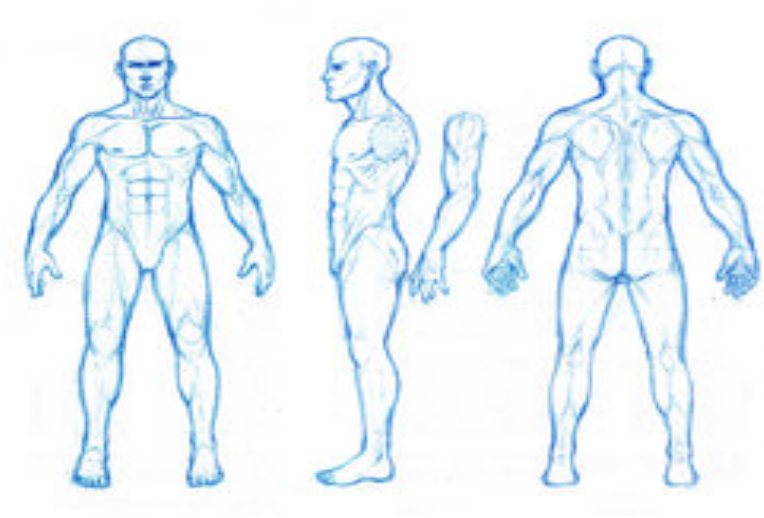
Special Equipment: (circle) NONE / Hearing Aids / Cane / Walker / Wheel Chair / Other:_____

Are you receiving **Home Health:** Yes / No Home Health Agency:_____

***Note:** If receiving home health, your Insurance cannot be billed and you will be responsible for charges

What do you expect from your treatment:_____

Please **circle affected areas and indicate pain level:**



Pain Intensity Scale:

0=no pain / 10=severe pain
(Please circle)

0

1 2 3

4 5 6

7 8 9

10

Provider Notes:_____

_____

_____

_____