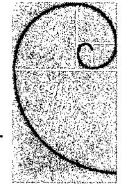
New Patient Intake Form



Patient's Name: ______________________________

DOB: ______________ Age: __________ Height: __________ Weight: __________

Physical Address: ______________________________
Billing Address: ______________________________

Home Phone: ______________ Cell Phone: ______________
Preferred Phone to be Contacted on (circle): **Home** **Cell** **Other**: ______________

E-mail: ______________________________

Referring Physician: ______________________________

Are you billing insurance for PT treatment? **YES** **No** Insurance Co.: ______________
(*Please leave blank if unknown*) My Deductible is: __________ Has it been met to date? **YES** **NO**
My Copay/Coinsurance is: __________ Effective date: ______________

Reason for today's visit: ______________________________
What is your goal for Physical therapy at this time?: ______________________________

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Have you **recently** noted any of the following (check all that apply)?

- ○ Changes in Appetite
- ○ Changes in Bowel or bladder function
- ○ Difficulty maintaining balance while walking
- ○ Difficulty swallowing
- ○ Dizziness/Lightheadedness
- ○ Fever/chills/sweats
- ○ Headaches
- ○ Nausea/vomiting
- ○ Pain at night
- ○ Shortness of breath
- ○ Weakness/fatigue
- ○ Weight loss/ gain

Have you **ever** been diagnosed with any of the following conditions (check all that apply)?

- ○ Anemia
- ○ Asthma
- ○ Cancer (type: ______________)
- ○ Chemical dependency (i.e., alcoholism)
- ○ Depression
- ○ Diabetes
- ○ Epilepsy
- ○ Heart disease
- ○ High blood pressure
- ○ Kidney/ Liver Problems
- ○ Lung Problems
- ○ Multiple Sclerosis
- ○ Osteoporosis
- ○ Pacemaker inserted
- ○ Parkinson's Disease
- ○ Rheumatoid arthritis
- ○ Stomach Ulcers
- ○ Stroke
- ○ Thyroid Problems
- ○ Other: ______________
- ○ Other: ______________

Surgeries or conditions in which you have been hospitalized for (type and date): ______________

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Current medications: ______________________________
Allergies: ______________________________

Consent to treat, benefit Assignment and Release of Information: By signing below, I hereby give consent for all Physical Therapy services provided by Progressive Physical Therapy, LLC all payments for services rendered. I authorize Progressive Physical Therapy, LLC to release and receive information concerning my treatment to medical providers, guarantor and/or insurance carriers.

______________________________ ______________________________

Patient/ Guardian Signature Date