Eclectic Physical Therapy
Jennifer Iannucci, MPT

Balance Dynamics PT
Anne Wolf, MPT

Patient Intake

Name ______________________________________ D.O.B.__________________
Email ____
Address ____
Phone (home) _______________________ (cell)__________________________
Communication PHI: phone message __(y/n), text ___(y/n), email__(y/n)
Preferred method of communication ___________________________________
Employer _________________________ Occupation: ___________________
Referring MD ____________________ Phone ________________________
In case of emergency contact: ____
How did you hear about us? ____

Insurance Company: See copy of card
policy number: ___________________________ Phone:_______________________

Medical Information:

1. Is this a result of a car accident? __(y/n)
2. Did this injury occur while working? __(y/n) If yes, provide Contact information or workman's compensation case manager. (name, phone, fax)
   ____
3. Are you currently in a lawsuit related to this injury? If yes, provide contact information. (name, phone. fax) ____
4. Have you participated in PT earlier this year? __(y/n) If yes, how many visits?______
5. Are you currently receiving homecare? ____(y/n)
6. Currently, are you being treated for THIS condition? ______Y ______N
   If yes, ______MD ______Physical Therapist ______Massage Therapist ____
   Chiropractor _______ Naturopath____ Acupuncture___Other_____________
7. Have you had diagnostic testing for THIS condition? ______Y ______N
   If yes, _____ X-ray _____CT Scan/MRI _____EMG/NCV ____Myelogram ______
8. Other Results:
   ____

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Current Condition/Limitation

Describe:____
____
____
Medical Diagnosis: ____
Onset Date:____/______/_____ Surgery Date (if applicable): ______/_____/_____

What is your general activity level? ___Inactive ____Moderately Active ____Very Active
What is your general stress level? ______Mild ______Moderate ______Severe

List 2 goals you'd like to accomplish through Physical Therapy:
1) ____
2) ____

Medical History: (please check all that apply)

__Allergies	__ Difficulty Breathing	__ Gynecological Issues
__ Asthma	__ Cancer	__ Heart Disease
__Dizziness	__ Fatigue	__ Pacemaker
__Bladder Infections	__ Kidney Disease	__Osteoporosis
__Edema (swelling)	__Childhood Orthopedic condition	__Skin (sensitivity, rashes, wounds)
__High Blood Pressure	__Swallowing Difficulty	__ Thyroid
__Diabetes	__ Lyme Disease	__ weight change
__ Chest Pain	__ Headache/Migraine	__ Pacemaker
__ Hot/cold Intolerances	__Concussion/head injury	__ Gastrointestinal
__ Vascular Condition	Other:	

Surgical History: (type and date)
____
____
____
Medication/Supplements:____
____
____
Are you currently pregnant or plan to be? ___ Yes ___ No ___N/A

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