TITAN Physical Therapy LLC • Phone: (862) 210–8675 • Fax: (862) 210-8419

New Patient Intake Form

1. PATIENT INFORMATION

Last Name	First Name	M.I.	DOB	Gender ☐ Female ☐ Male
Address	City		State	Zip
Home Phone	Cell Phone		Social Security Number	
Email Address	Referral Information ☐ Internet ☐ Physician ☐ Ad ☐ Patient			
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Domestic Partner				
Employer's Name	Occupation			
Emergency Contact	Phone Number	Relationship to Patient		
Primary Care Physician's Name	Office Number			
Injury: ☐ Work Related ☐ Auto Related ☐ Other Liability ☐ Not Applicable				

2. INSURANCE INFORMATION

PRIMARY INSURANCE INFORMATION

Insurance Carrier/Auto Insurance Company	Phone Number
Policy/Claim Number	Group Number
Subscriber's Name	Subscriber's DOB	Subscriber's Relationship to Patient

SECONDARY INSURANCE INFORMATION

Insurance Carrier/Auto Insurance Company	Phone Number
Policy/Claim Number	Group Number
Subscriber's Name	Subscriber's DOB	Subscriber's Relationship to Patient

3. FOR MEDICARE PATIENTS ONLY (otherwise, please continue onto section 4)

Is patient currently receiving home care services? ☐ Yes ☐ No	If yes, what's the expected date of completion?
Does the patient have a home care discharge letter? ☐ Yes ☐ No	

4. FOR AUTO ACCIDENT/WORKER'S COMPENSATION INJURIES ONLY (otherwise, continue onto section 5)

Date of Accident	Have you completed an Application of Benefits? ☐ Yes ☐ No
Type of Accident: ☐ Auto ☐ Slip & Fall ☐ Worker's Compensation	Patient was: ☐ Driver ☐ Passenger ☐ Pedestrian
Were you: ☐ Pedestrian ☐ Rear-ended ☐ Hit Head-on ☐ Broad-sided	Was injury related to accident? ☐ Yes ☐ No
Do you have an attorney? ☐ Yes ☐ No	Law Firm
Attorney's Name	Attorney's Phone Number
Insurance Adjuster's Name	Phone Number

5. GENERAL INFORMATION

Current Medications (prescriptions, over-the-counter): _____

_____

Are you allergic to any medications? ☐ Yes ☐ No If yes, please list medications: _____

_____

Please list any other allergies: _____

_____

Are you suffering from any of the following?

☐ Headache "like no other"	☐ Night Pain	☐ Imbalance/Falls
☐ Bowel/bladder Dysfunction	☐ Loss of Appetite	☐ Fine Motor Difficulty
☐ Unexpected Weight Loss	☐ Severe Fatigue	☐ Memory Loss
☐ Drowsiness	☐ Blurred Vision	☐ Other: _____

Have you been told you have any of the following?

☐ Aortic Aneurysm	☐ Fainting/Dizziness	☐ Rheumatoid Arthritis
☐ Asthma	☐ Fracture	☐ Severe Hemophilia
☐ Bone Tumor	☐ Heart Conditions	☐ Spinal Instability
☐ Cancer	☐ Hepatitis B/C	☐ Stroke
☐ Carotid Artery Dissection	☐ HIV	☐ Thyroid Problems
☐ Cauda Equina	☐ Myelopathy	☐ Tuberculosis
☐ Congenital Dysplasia	☐ Osteomalacia	☐ Other: _____
☐ Diabetes	☐ Osteoporosis	_____

Have you ever fainted or experienced a seizure? ☐ Yes ☐ No If yes, frequency: _____

Please list any surgeries you have had in the past: _____

_____

Please list any past and current medical equipment you have been using: _____

_____

Please indicate reason for visit: _____

_____

When did your symptoms begin? _____

Nature of pain/symptoms: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Aching ☐ Tingling

Frequency of pain: ☐ Occasional ☐ Constant ☐ Periodic

Which of the following best describes how your injury occurred?

☐ A Fall ☐ Trauma ☐ MVA (Car Accident) ☐ Overuse ☐ Incident at Work

☐ Degenerative Process ☐ Unknown ☐ During recreation/sports ☐ Other: _____

The onset/timing of this episode was: ☐ Gradual ☐ Sudden

Any previous episodes? ☐ Yes ☐ No

As the day progresses, your symptoms: ☐ Increase ☐ Decrease ☐ Stay the same

Does the pain wake you up at night? ☐ Yes ☐ No

Do you have pain/stiffness upon getting out of bed in the morning? ☐ Yes ☐ No

Problem improves with: (check all that apply) ☐ Movement ☐ Bending ☐ Walking

☐ Rest ☐ Turning ☐ Standing ☐ Lying ☐ Sitting ☐As the day progresses

Problem worsens with: (check all that apply) ☐ Movement ☐ Bending ☐ Walking

☐ Rest ☐ Turning ☐ Standing ☐ Lying ☐ Sitting ☐ As the day progresses

Do you have any other conditions that may limit your response to exercise? ☐ Yes ☐ No

If yes, please indicate: _____

Has your injury affected your ability to work? ☐ Yes ☐ No

On a scale of 0-10 (0 is no pain, 10 is work pain imaginable), circle the number that best describes your pain:

Your current pain:	0	1	2	3	4	5	6	7	8	9	10
At worst:	0	1	2	3	4	5	6	7	8	9	10
At best:	0	1	2	3	4	5	6	7	8	9	10

Has your injury affected your ability to work? ☐ Yes ☐ No

Are there any daily activities that have been limited by your injury? ☐ Yes ☐ No

If yes, please indicate activities: _____

Use the symbols to localize what type(s) of pains/sensations you are feeling on different areas of your body using the body chart below:

** = sharp pain / / = dull pain

+ + = throbbing pain @@ = tingling

= aching pain ● ● = constant pain

< < = periodic pain ~ ~ = occasional pain