MOBILE HEALTH
PHYSICAL THERAPY

PATIENT INTAKE FORM

Patient Information:

Last Name: _____ First Name: _____

Sex: Male / Female Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone Number: _____ Mobile Number: _____

Email Address: _____

Preferred Method for Communication: (circle one) Text / Phone call / Email

Employer's Name: _____

Occupation: _____

Work Phone Number: _____ Is this a work related injury: Yes / No

Is this injury related to an auto accident: Yes / No

Primary Care Physician: _____

Referring Physician: _____

Emergency Contact: _____ Phone Number: _____

Insurance Information:

Insurance Company Name:_____ Policy #:_____

Address: _____ City: _____ State: ____ Zip Code: _____

Insured's Name: _____ SS#: _____-_____-_____ Date of Birth: _____

Address: _____ City: _____ State: ____ Zip Code: _____

Insured's Employer's Name: _____

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Medical History:

Diagnosis (if known): _____ Onset Date: _____

What is your major complaint:_____

Previous Treatment for this problem: _____

Have you had special tests for this problem (X-ray, MRI, CT scan, etc.): _____

Allergies: _____

Are you currently pregnant? Yes / No If yes, how many weeks gestation: _____

Patient Medical History:

Please indicate if you currently have, or have had previously, any of the problems listed below, check all that apply:

- ☐ Autoimmune disorder
- ☐ Cancer
- ☐ Bleeding or clotting disorders
- ☐ Osteoporosis
- ☐ Shortness of breath, breathing disorders
- ☐ High blood pressure
- ☐ Neurological disorders
- ☐ Communicable disease (TB, HIV/AIDS, etc.)
- ☐ Recent changes in bowel/bladder function
- ☐ Falls, loss of consciousness
- ☐ Heart or Vascular Problems
- ☐ Blood clots
- ☐ Diabetes
- ☐ Dizziness or vertigo
- ☐ Recent changes in weight/appetite
- ☐ Skin problems, rashes, discoloration
- ☐ Blood clots, DVT
- ☐ Infection
- ☐ Addiction disorder
- ☐ Changes in vision

Please list any past surgeries and dates: _____

_____

Please list all medications you are currently taking: _____

_____

Any other illness/injury we should be aware of: _____

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PHYSICAL THERAPY

Please indicate areas of pain/discomfort on this body diagram: