JEFF LAHTI PHYSICAL THERAPY

Physical Therapy Intake and Medical History Form

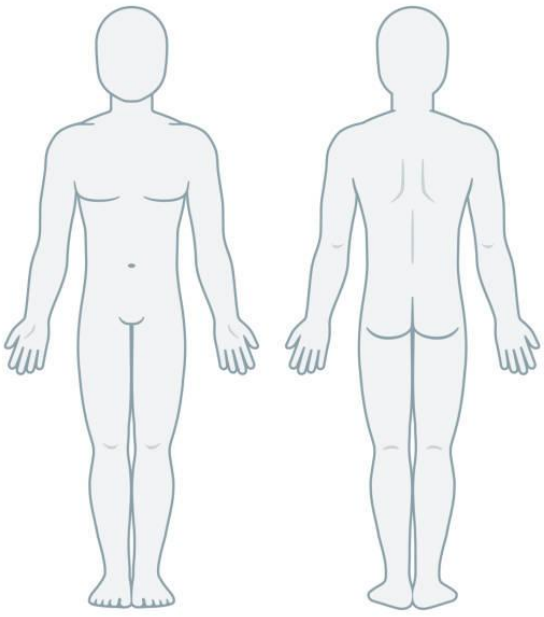
Date:_____

First Name:	**Last Name:**	
DOB:	**Email:**	**Phone:**
Street Address:		
City:	**State:**	**Zip**

What is the best method for us to communicate with you? ⬜ Phone ⬜ Text ⬜ Email

Referring physician:	
Primary Care Physician and contact information: ***(if different than referring physician)***	
Emergency Contact Name:	**Relationship:**
Emergency Contact Number:	
What is the reason for your visit?	

Please indicate on the drawings below the areas of your body this problem exists:



How would you describe the symptoms that you are experiencing? *(check all that apply)*

⬜Numbness ⬜Tingling ⬜Burning ⬜Stabbing ⬜Throbbing ⬜Aching ⬜Pins & Needles

Patient Initials_____

When did the problem start and what do you think originally caused it?

Have you experienced these symptoms before? ⬜ Yes ⬜ No (if yes, please explain below)

Since the problem started, your symptoms have…

⬜ Worsened ⬜ Improved ⬜ Remained about the same

Describe any changes in your symptoms.

Circle your current pain level.
(0=no pain/10= worst pain imaginable)

0 1 2 3 4 5 6 7 8 9 10

What do you think INCREASES your symptoms?

What do you think DECREASES your symptoms?

Have you had any diagnostic test done for your current symptoms (e.g. MRI, X-ray, CT Scan, etc.)? ⬜ Yes ⬜ No (if yes, please please indicate tests below)

Are you receiving or have you received other treatment for this condition?

Patient Initials_____

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PLACE AN X FOR ANY CONDITIONS YOU HAVE AND COMMENT IN SECTION ON BOTTOM OF PAGE

Asthma, Bronchitis, or Emphysema		Elbow/Hand Injury	
High Blood Pressure		Osteoporosis	
Anemia		Vision or Hearing Difficulties	
Shortness of Breath/Chest Pain		Neck Injury/Surgery	
Heart Attack or Surgery		Stroke/TIA	
Diabetes		Sleep Problems/Difficulties	
Coronary Heart Disease or Angina		Back Injury/Surgery	
Thyroid Trouble/Goiter		Blood Clot/Emboli	
Gout		Leg/Ankle/Foot Injury/Surgery	
Cancer/Chemotherapy/Radiation		Knee Injury/Surgery	
Dizziness or Fainting		Epilepsy/Seizures	
Weakness		Weight Loss/Energy Loss	
Emotional/Psychological Problems		Arthritis/swollen Joints	
Infectious Diseases		Varicose Veins	
Hernia		Joint Replacement	
Bowel or Bladder Problems		Any Pins or Metal Implants?	
Allergies		Do you have a Pacemaker?	
Severe or Frequent Headaches		Do you smoke?	
Shoulder Injury		Are you Pregnant?	
Please explain all YES answers below:			

Patient Initials_____

Please list current medications and supplements below:

Patient Guidelines

- Please provide a 24-hour notice for appointment cancellations.
- Please be aware that we are a self-pay clinic and payments are due at the time of the services rendered.

By my signature below, I certify that the information I have provided above is complete, accurate and truthful to the best of my knowledge and I agree to pay in full at the time of my appointment.

⬜ Check if you need documentation for HSA/Flex submission

Patient Signature_____ Date _____

Parent/Guardian Signature *(if applicable)* _____ Date _____

Parent/Guardian Name (please print) _____

Patient Initials_____