

**ALLCARE PHYSICAL THERAPY
PATIENT INTAKE FORM**

Patient Demographics:

Last Name _____ **First Name** _____

Address _____ **City** _____ **State** _____ **Zip** _____

Telephone _____ **Cell** _____ **SS#** _____

Date of Birth _____ **Sex** _____ **Marital Status** _____ **Spouse's Name** _____

Employer _____ **Work Address** _____

Work Phone _____ **Occupation** _____

Emergency contact Name _____ **Emergency contact #** _____

How did you find us? _____

Have you received physical therapy this year? _____ **Where?** _____

Do you or have you received Homecare services this year? _____

Insurance Information:

Primary Insurance: _____ **ID#** _____

Name of Insured _____ **Relationship to patient** _____ **Date of Birth** _____

Secondary Insurance: _____ **ID#** _____

Name of Insured _____ **Relationship to patient** _____ **Date of Birth** _____

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Medications List:

Date: _____

Please list all the medications you are currently taking, also include the dosage:

1. _____

2. _____

3. _____

4. _____

5. _____

Pain Questionnaire:

Please describe the location of your pain. _____.

The words below describe average pain. Place a check mark in the column that represents the degree to which you feel that type of pain.

		<u>None</u>	<u>1</u>	<u>Mild</u>	<u>2</u>	<u>Moderate</u>	<u>3</u>	<u>Severe</u>
Throbbing	0		1		2		3	
Shooting	0		1		2		3	
Stabbing	0		1		2		3	
Sharp	0		1		2		3	
Cramping	0		1		2		3	
Gnawing	0		1		2		3	
Hot-Burning	0		1		2		3	
Aching	0		1		2		3	
Heavy	0		1		2		3	
Tender	0		1		2		3	
Splitting	0		1		2		3	
TiringExhausting	0		1		2		3	
Sickening	0		1		2		3	
Fearful	0		1		2		3	
Punishing-Cruel	0		1		2		3	