PELLETIER & KILLIAN PHYSICAL THERAPY
Intake Form for New Episode

Name: _____ Date: _____

Your condition/diagnosis requiring physical therapy: _____
Referring Physician: _____
Physician phone number: _____

When did pain start: _____ Date of injury: _____
Describe nature of problem: _____
_____
Is this workers compensation or an automobile injury? Y or N (circle one if applicable)

Tests done and findings: _____

Insurance company the same as previous? Y or N (circle one)
If no, please provide us with updated copy of your insurance card.

Signature: _____
*** I hereby allow this facility to treat and submit all bills and accompanying information to my insurance company for compensation. I also consent to treatment by the licensed personnel of this facility.**

*** For your information, we will be sending your PT evaluation and re-evaluations, to your physician for signature to certify your plan of care, as required by Medicare. This needs to be signed within 30 days of your initial visit, in order for insurance to cover your visits.**

Date: _____

Name: _____

Chief Complaint or Symptoms you are having: _____

Past (or current) treatment undergone for this problem (chiropractor, acupuncture, PT)
_____

Please indicate if you are active in an exercise program, either currently or in the past before symptoms started. _____

When did your symptoms start?
_____

We need to know what your level of discomfort is on a pain scale, 0-10 (10 being the worst), so that we can formulate functional goals for your recovery.
Current _____ Best _____ Worst _____
Constant _____ Frequent _____ Occasional _____
with what activity, primarily? _____

Any recent injuries, or life stressors, that may be contributing factors (accidents, falls, MVA)?
_____

Please circle any of the following conditions you have experienced:

Neck or back conditions	Carpal Tunnel Syndrome	Frozen shoulder	Rotator Cuff
Knee pain/surgery	Ankle disorders	Plantar fasciitis	Hip issues
Numbness/tingling	Restless legs	Can't relax	Dissociate
Headaches	Vertigo or PTSD	Spiritual experiences	Head injury
Dizziness	Generalized weakness	Chronic fatigue	Depression
Hearing loss	Tinnitus	Visual loss	Visual issues
Stomach issues	Heart issues	Thyroid issues	Diabetes
Recent weight loss	Pregnancy	Other _____	

Any Medications? _____
_____

Past Medical, Surgical, and Orthopedic History (and dates):
_____
_____

Rate your overall health: poor satisfactory good excellent (circle one)

What are you most concerned about with regards to your current state of health?
_____

What alternative approaches do you use to address your condition (meditate, breath, nutrition, yoga, tai chi, frequency raising devices, oils, etc)?

FUNCTION
What repetitive activities/hobbies do you do in daily life (computer, garden, reading)?
_____
What positions or activities cause your pain?
_____
What positions or activity alleviate you pain?
_____

DAILY STRESSORS
What are daily situations that are causing you the most frustration in life now?
_____
Any difficulty sleeping? _____
Any difficulty dealing with life, in general right now? _____
Any increased anxiety, since dealing with this current issue/body pain condition?
_____

Thank you for taking the time to answer these questions that help us formulate your personal treatment plan. We are here to serve you in your return to a more whole, and natural, wellness state of being.

Sincerely, the staff at Pelletier & Killian Physical Therapy

CONSENT TO APPOINTMENT REMINDERS

I, _____, give permission to Pelletier & Killian Physical Therapy to send me an: (fill in contact preference)

e-mail _____

or a text message at _____

to remind me of my appointment(s) for Physical Therapy.

Sincerely: _____

Date: _____