Black Rock Physical Therapy
Patient Intake

Date_____

Name _____ D.O.B._____

Email _____ SSN#_____

Address _____ Phone _____
(Home) (Home)
_____ Cell
_____

Employer _____ Occupation_____

Address _____ Phone_____

_____

PCP _____ Phone _____
(Primary care physician) (PCP)

Address _____

Referring MD _____ Phone _____
(If Applicable) (Ref. MD)

Address: _____

Any other health professionals consulted for this problem?

_____

Insurance Company _____ Phone _____
(If Applicable)
Policy # _____

Emergency Contact _____ Phone_____

Relationship _____

How did you hear about Black Rock Physical Therapy?

_____

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Medical History:
Please check all that apply:

___Allergies, Asthma, Hay fever
___Bladder Infections
___Breathing Difficulty
___Cancer
___Chest Pain
___Concussion/Head Trauma
___Diabetes
___Dizziness
___Edema (Regional swelling)
___Epilepsy
___Fatigue
___Gastrointestinal Issues
___Gynecological Issues
___Heart Disease
___Headache/Migraine
___Childhood Orthopedic Conditions
___Hepatitis/Jaundice
___High Blood Pressure
___Hot/Cold Intolerance
___Kidney Disease
___Lyme Disease
___Osteoporosis
___Pacemaker
___Phlebitis
___Psychiatric (anxiety, depression etc)
___Skin (sensitivity, rashes, wounds)
___Swallowing Difficulty
___Thyroid
___Vascular Condition
___Weight Change
__Other_____

Medication/Supplements:

Name	Amount	Condition
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you currently pregnant or plan to be? ___ Yes ___ No ___N/A

Have you ever had surgery or been hospitalized? Explain:

_____

_____

Are you presently involved in an exercise program or have you been?

_____

When did symptoms start? _____Work Injury? _____ Auto? _____

List 3 Goals you'd like to accomplish through Physical Therapy:

1) _____
2) _____
3) _____

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Body Chart

Please tell us about your symptom(s):

= Pain

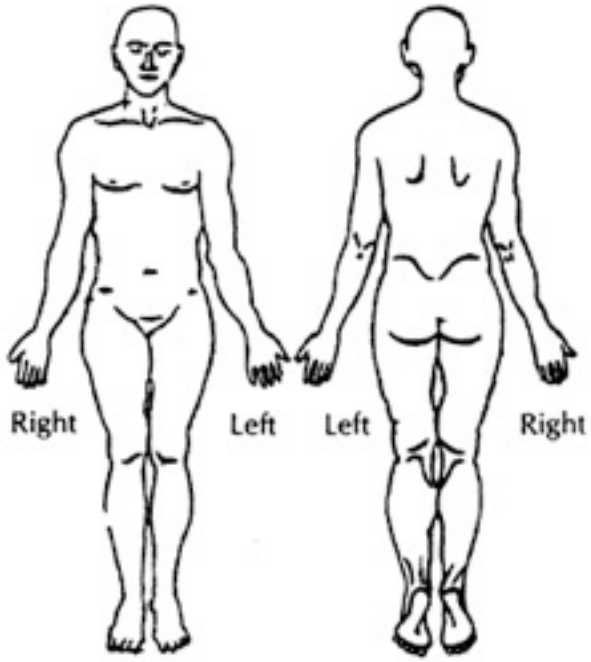
= Pins and Needles

= Numb/Cold

= Tight/Stiff

= Other (describe)

_____



Anything else we need to know?

_____

_____

I understand I am responsible for:
1) Notifying BRPT of Primary Care Physician's name and changes in medical status and personnel.
2) Giving 24 hour notice for cancellation except for illness or emergency.
3) Paying for treatment after each appointment unless other arrangements have been made.

I authorize Black Rock Physical Therapy LLC to furnish full details of my medical care to my physician, insurance company and attorney (if applicable) and to request any records or reports pertaining to my care.

_____ Date _____

If under age 18, parent/ guardian:

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