# Patient Intake Form

**Last Name:** ______________________ **First Name:** ________________________ **MI:** ________

**SSN:** _____________________ **DOB:** _________________ **Marital Status:** ________________

**Email Address:** ____________________________________________________________

**Home Phone:** __________________________ **Cell Phone:** ______________________________

**Cellular Carrier:** Verizon AT&T T-Mobile/Sprint Other: ___________________

**Primary Address:** ___________________________________________________________
(City) (State) (ZIP Code)

**Secondary Address:** _________________________________________________________
(Optional) (City) (State) (ZIP Code)

**How did you hear about Sol?** ________________________________________________

### *EMERGENCY CONTACT*

**Name:** ____________________________________ **Relation:** __________________________

**Home Phone:** __________________________ **Cell Phone:** ______________________________

### *EMPLOYER INFORMATION*

**Company Name:** ______________________________ **Phone:** ___________________________

**Company Address:** ___________________________________________________________
(City) (State) (ZIP Code)

### *INJURY INFORMATION*

**Classification of Injury (please select one):**

Motor Vehicle Accident **State Accident Occured:** ________________

Workers' Compensation

None of the above

**Date of Injury:** _________ **Claim Number:** ______________________

**Attorney Name:** ______________________________ **Attorney Phone:** _____________________

**Attorney Email:** ______________________________________________

## *EMAIL & TEXT NOTIFICATIONS*

Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to send you a billing statement, to obtain feedback on your experience with our healthcare team, or to provide general health reminders and information. The practice does not charge for this service, but standard messaging and data rates may apply, as provided in your wireless plan. Contact your carrier for details.

**My preferred method of contact for the aforementioned notifications is:** Text Message Email

**I consent to receiving email and text notifications from Sol Physical Therapy.**

**Initial here:** ____________

It is the patient's responsibility to schedule all appointments. We recommend you schedule in advance, as there are no "standing" appointments. Please check with the front desk before leaving each appointment, to ensure we have you scheduled or have an available opening for you.

**Initial here:** ____________

## *RELEASE OF INFORMATION*

**I authorize Sol Physical Therapy to release the following type of information to my approved list of contacts:**

Obtain appointment times and make changes to my scheduled appointments

Call and inquire about or obtain my billing information

Pick up requested documentation

**Approved list of contacts for release of information:**

__________________________ __________________________

__________________________ __________________________

I do not wish to release any personal information to anyone

**Initial here:** ____________

______________________________

**Patient Name (Please Print)**

______________________________ ______________

**Patient or Guardian Signature** **Date**

SOL PHYSICAL THERAPY

# Patient Medical History

**Last Name:** ______________________________ **First Name:** ________________________________ **MI:** __________

**Height:** ____ ft _____ in **Weight:** _______lbs **Sex:** Male Female Decline to answer

**BMI:** Underweight Normal Overweight Obese

**Describe your overall health:** Excellent Very Good Fair Poor

**Have you had any falls in the past 12 months?** Yes No

**If yes, when, and how frequently?** ______________________________________________________________________

**Personal Medical History:**

| | Yes | No |
|---|---|---|
| Vascular Disorders | | |
| Rheumatoid Arthritis | | |
| Osteoarthritis | | |
| Osteoporosis | | |
| High Blood Pressure | | |
| Low Blood Pressure | | |
| Diabetes | | |
| Cancer | | |
| Autoimmune Disorders | | |
| Hepatitis | | |
| Seizures | | |
| Stroke | | |

| | Yes | No |
|---|---|---|
| Heart Trouble | | |
| Smoker | | |
| Neck Pain | | |
| Back Pain | | |
| TMJ | | |
| Asthma | | |
| Allergies | | |
| Pacemaker | | |
| Are you pregnant? | | |
| History of Substance Abuse | | |
| Other: | | |

**Are you experiencing any of the following:**

| | Yes | No |
|---|---|---|
| Pain or Tightness in Chest | | |
| Fainting Spells | | |
| Bruise Easily | | |
| Memory Problems | | |

| | Yes | No |
|---|---|---|
| Low Blood Pressure | | |
| Shortness of Breath | | |
| Incontinence | | |
| Constipation | | |

**Surgical History** See attached surgery list

______________________________________________________________________

**Current Medications & Supplements:** See attached medication list

______________________________________________________________________

SOL PHYSICAL THERAPY

# Patient Injury Questionnaire

**Referring Physician:** ____________________

**Primary Care Physician:** ____________________

**What part of your body will we be treating?** ____________________

**Date of injury or onset of symptoms:** ____________________

**Have you had surgery for this injury?** Yes No **Date of surgery:** ____________________

**Describe how injury occurred:** ____________________

____________________

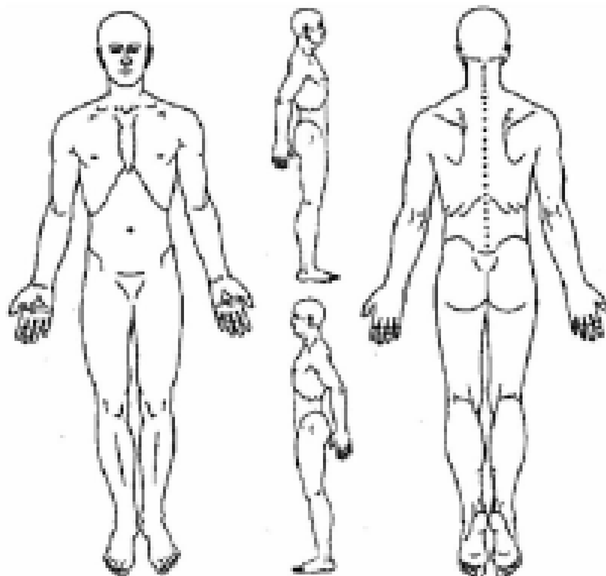
**Diagnostic tests completed:** MRI CT Scan X-Ray Other: ____________________

**Are you working?** Yes No **If yes, has injury restricted your employment?** Yes No

**If yes, are you:** Restricted Unable to work

**Have you seen any other provider within the last 30 days for this condition (i.e. massage therapist, chiropractic, athletic trainer, or acupuncturist)?** Yes No **If yes, by whom?** ____________________

**Pain Scale:** no pain = 0, worst pain ever = 10 **Current (0-10):** __________ **At its worst (0-10):** __________



**Circle area of injury/discomfort and describe below:**

____________________

____________________

____________________

____________________

____________________

____________________

____________________

____________________