New Patient Intake Form

Alliance
Outpatient Physical Therapy
and Wellness Services

Name: ____ **Primary Care Physician:**______________________________

Have you RECENTLY noted any of the following (check all that apply)?

- ❑ changes in appetite
- ❑ changes in bowel or bladder function
- ❑ difficulty maintaining balance while walking
- ❑ difficulty swallowing
- ❑ dizziness/lightheadedness
- ❑ fever/chills/sweats
- ❑ headaches
- ❑ nausea/vomiting
- ❑ pain at night
- ❑ shortness of breath
- ❑ weakness/fatigue
- ❑ weight loss/gain

Have you EVER been diagnosed with any of the following conditions (check all that apply)?

- ❑ anemia
- ❑ asthma
- ❑ cancer (type)______________________
- ❑ chemical dependency (i.e., alcoholism)
- ❑ depression
- ❑ diabetes Check One: Type 1 Type 2
- ❑ epilepsy
- ❑ heart disease
- ❑ high blood pressure
- ❑ kidney/liver problems
- ❑ lung problems
- ❑ multiple sclerosis
- ❑ osteoporosis
- ❑ pacemaker inserted
- ❑ Parkinson's disease
- ❑ rheumatoid arthritis
- ❑ stomach ulcers
- ❑ stroke
- ❑ thyroid problems
- ❑ other_________________
- ❑ other_________________

During the past month have you been feeling down, depressed or hopeless? YES NO
During the past month have you been bothered by having little interest or pleasure in doing things? YES NO
Is this something with which you would like help? YES YES, but not today NO

Do you smoke? YES NO ______ pack/day

Height:____________________ **Weight:** ___________________

FOR WOMEN: Are you currently pregnant or think you might be pregnant? **YES NO**

Are you currently taking blood thinning or anticoagulant medications for any medical conditions? **YES NO**

ALLERGIES: ________ ____
Are you latex sensitive? **YES NO**

Please list any surgeries or other conditions for which you have been hospitalized, including dates:
1. ______________________________ 2.________________________________ 3.__________________________________

For the injury you are seeing us for today:

Pain at LOWEST: Rate your lowest pain level IN THE PAST 3 DAYS.

0 1 2 3 4 5 6 7 8 9 10
No pain — Worst pain Imaginable

Pain Currently: Rate your level of pain now.

0 1 2 3 4 5 6 7 8 9 10
No pain — Worst pain Imaginable

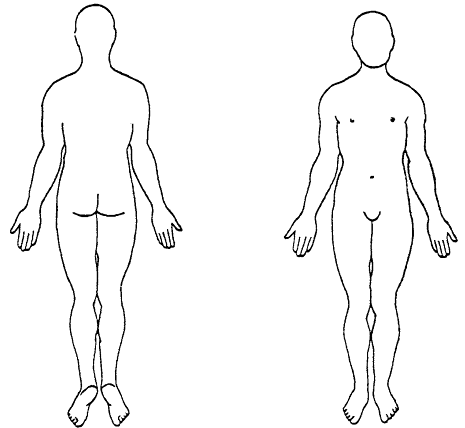
Pain at WORST: Rate your highest pain level IN THE PAST 3 DAYS.

0 1 2 3 4 5 6 7 8 9 10
No pain — Worst pain Imaginable

Body Chart:

Please mark the location of your pain and type of pain on the chart:

Key:
X sharp stabbing pain
O Dull achy pain
….Numb/Tingling
/// Throbbing
== Burning



What is your goal for therapy at this time?____

Patient/Guardian/Responsible Party Signature:____ **Date:**_______________