FIT AT HOME
PHYSICAL THERAPY & REHABILITATION

FIT AT HOME

New Client Intake Form

Client Information:
Patient First Name: _____ Patient Last Name: _____ DOB: _____

Address: _____ City/State: _____ Zip Code: _____

Phone: _____ Secondary Phone: _____ Email: _____

Emergency Contact Name: _____ Emergency Contact Phone: _____

Referring Provider: _____ Referring Provider Phone: _____

Do you authorize us to contact your physician to share patient health information/medical records? Yes ____ No ____

How did you hear about us? _____

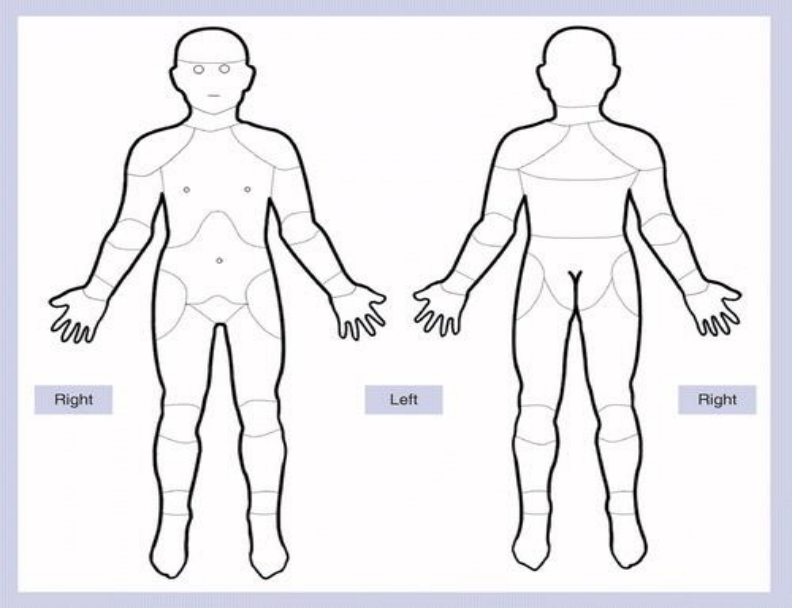
Primary Concerns/Pain:
Please describe your primary complaint or reason for seeking physical therapy.

_____

_____

Are you currently experiencing pain? Yes ____ No ____ Approximately how long have you had pain? _____

Please mark the diagram in locations corresponding with your pain or symptoms.



Choose any of the following to describe your pain:

- ☐ Aching
- ☐ Cramping
- ☐ Numbness/Tingling
- ☐ Intermittent
- ☐ Burning
- ☐ Dull
- ☐ Sharp/Stabbing
- ☐ Throbbing

Does pain interrupt your sleep?

Yes ____ No ____

Rate the severity of your pain or discomfort, using a 0-10 scale. (0 = no pain, 10 = severe pain)

1 2 3 4 5 6 7 8 9 10

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What activities or treatments make your pain worse:

_____

What activities or treatments improve or relieve your pain:

_____

Have you attempted any of the following treatments to relieve your pain in the past? (Check all that apply):

- ☐ Massage
- ☐ Ice/Heat
- ☐ Surgery
- ☐ Medications
- ☐ Chiropractic care
- ☐ Physical Therapy
- ☐ Injections
- ☐ Rest

Past Medical History:

Medical History (Check all that apply):

- ☐ High blood pressure
- ☐ Cancer
- ☐ Heart/Coronary disease
- ☐ Rheumatoid Arthritis
- ☐ Diabetes
- ☐ Hernia
- ☐ Stroke/CVA
- ☐ Dizziness/fainting
- ☐ Tobacco use
- ☐ Currently pregnant
- ☐ Seizures
- ☐ *Allergies*
- ☐ Headaches
- ☐ Neurological disorders
- ☐ Asthma/breathing difficulty
- ☐ Osteoporosis/penia
- ☐ Recent fracture
- ☐ Pacemaker
- ☐ Bowel/bladder dysfunction
- ☐ *Prior surgeries*

Please list any other present or chronic medical conditions you have:

_____

_____

Please list any prior surgeries/dates:

_____

_____

Known allergies: _____

Medications: _____

Lifestyle/Activity Goals:

Rate your CURRENT level of activity, using a 0-5 scale. (0 = bedridden, 5 = very active)

1 2 3 4 5

If applicable, rate your activity level PRIOR to this injury or onset of pain, using a 0-5 scale. (0 = bedridden, 5 = very active)

1 2 3 4 5

List your primary goals for your physical therapy treatment:

_____

_____

I understand it is up to me to inform the physical therapist/staff about health conditions or allergies that I may have. I certify that the information I have filled out is correct and complete to the best of my knowledge. I must also inform the physical therapist about any medications/supplements that I am taking. I hereby agree and give consent for Fit at Home Physical Therapy to evaluate and furnish care that is considered necessary in the diagnosing or treating of my physical condition.

Patient Signature: _____ Date: _____