HARTER Physical Therapy
19931 W. Kellogg Suite A
Goddard, KS 67025
Phone: (316) 550-6132
Fax: (316) 550-6215

Patient Intake Form

Last Name: _____ First Name: _____ Middle Initial: _____
Date of Birth: _____ SSN: _____ - _____ - _____ Sex: o Male o Female
Marital Status: o Single o Married o Divorced o Widowed Are you sensitive/allergic to latex? o Yes o No
Height: _____ Weight: _____ Allergies: _____
Primary Care Physician: _____ Date of last examination by your PCP: _____
Home Address: _____ Building/Apt #: _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Injured Area: _____ Date of Injury: _____
Did this injury occur during a period of increased stress in your life? o Yes o No
If Yes, please provide a brief description: _____

What health provider's care are you currently under/seeing regularly?
o Primary Care/Family Physician o Chronic Pain Physician o Psychiatrist/Psychologist o Surgeon
o Neurologist o Homeopathic Doctor o Chiropractor o Personal Trainer
o Other: _____
Have you ever regularly used tobacco products? o Yes o No
Do you currently use tobacco products? o Yes o No
How many packs per day? _____

How did you hear about us? _____

PLEASE CHECK IF YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING:

o Diabetes	o COPD/Emphysema	o Hemophilia
o Chest Pain/Angina	o Thyroid Problems	o MRSA
o Heart Disease	o Osteoporosis/Osteopenia	o Special Dietary Guidelines
o High Blood Pressure	o Arthritis	o HIV/AIDS
o Heart Attack	o Rheumatoid Arthritis	o Hepatitis
o Pacemaker	o Ankylosing Spondylitis	o Asthma
o Vascular Disease	o Fractures	o Depression
o CVA/Stroke/TIA	o Bone Disease/Paget's/Osteomyelitis	o Anxiety
o Seizures	o Liver/Gallbladder Problems	o Allergies: _____
o Skin Abnormalities	o Kidney Problems	o Cancer: _____
o Pulmonary Embolism	o Bowel or Bladder Problems/Changes	o Hernia
o Blood Clots/DVTs	o Incontinence	o Sexual Dysfunction
o Chemical Dependency	o Motor Vehicle Accident	o Amyotrophic Lateral Sclerosis (ALS)
o Multiple Sclerosis (MS)	o Parkinson's Disease	Are you Pregnant? o Yes o No

o Surgeries: _____
o Other: _____

Occupation

Employer: _____ Phone: _____
Job Description: _____

Insurance Information

Primary Insurance: _____ Insured Name: _____
Date of Birth of Insured: _____

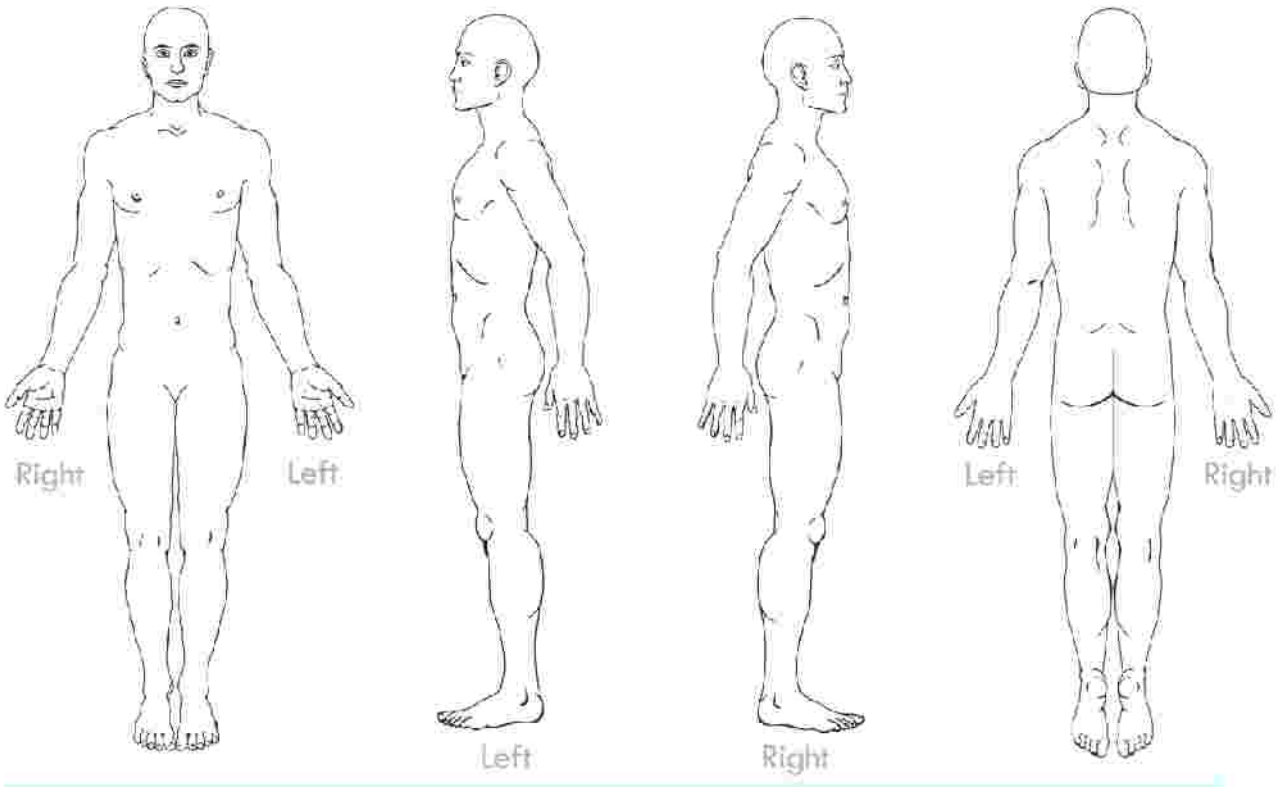
Secondary Insurance: _____ Insured Name: _____
Date of Birth of Insured: _____

Referring Physician: _____ Phone number: _____
(If no referring physician, just write "Direct Access")

Are you receiving or have you recently received home health services? o Yes o No
Are you receiving of have you recently received other therapy services? o Yes o No

Patient Signature: _____ Date: _____

Use this diagram to illustrate your pain/condition



Use the pain scale description for the following questions

0 No Pain
1 Mild Pain; you are aware of it, but it doesn't bother you
2 Moderate Pain that you can tolerate without medication
3 Moderate Pain that requires medication
4-5 More Severe Pain; you begin to reduce your activity level
6 Severe Pain
7-9 Intensely Severe Pain; you avoid the majority of activities due to your pain
10 Most Severe Pain; it may require a visit to the Emergency Room

What is your current pain?	0 1 2 3 4 5 6 7 8 9 10
What is your pain at best?	0 1 2 3 4 5 6 7 8 9 10
What is your pain at worst?	0 1 2 3 4 5 6 7 8 9 10

Do you have times where you are pain free? o Yes o No
Is there a time of day your symptoms seem worse? (check all that apply)
o Upon Awakening o Morning o Afternoon o At night

How would you describe your pain? o Dull Ache o Sharp o Burning o Stabbing o Throbbing
o Pins and Needles o Radiating o Other: _____

Do you experience any numbness or tingling? o Yes o No If Yes, where? _____

What activities do you have difficulty performing due to your current condition? _____

_____

What makes your pain/condition better? _____

_____

What makes your pain/condition worse? _____

_____

How would you rate your current health? o Excellent o Very Good o Good o Fair o Poor

In the past year have you experienced a fall? o Yes o No If Yes, did the fall cause an injury? o Yes o No
How many times have you fallen?_____ When was the most recent fall? _____

What personal goals do you hope to achieve with physical therapy? _____

_____

_____

Medication List

Please provide your most up to date medication and vitamin/herb/supplements list in the form below.

	Medication Name	**Dosage**	**Frequency**	**Reason Taking**
Example	*Lotrel*	*10mg*	*1 time per day*	*High blood pressure*
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
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11.				
12.				
13.				
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18.				
19.				
20.				