



400 Summit Drive
Lockport, IL 60441
(815) 838 - 9441

24520 S. Route 52
Manhattan, IL 60442
(815) 412 - 0580

New Patient Intake Form

Patient Information

Name: _____ Date: ____/____/____

Address: _____ City: _____

State: _____ Zip: _____

Date of Birth: ____/____/____ Age: _____ Gender: _____

Home Phone: (____) _____ Cell Phone: (____) _____

E-Mail: _____

Occupation/Job Title: _____

Insurance Information

Primary Insurance Carrier: _____

Identification Number: _____ Group Number: _____

Secondary Insurance Carrier: _____

Identification Number: _____ Group Number: _____

I do not have medical insurance

Emergency

Emergency Contact Person: _____

Phone Number: _____ Relationship: _____



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Medical History

Injury / Condition: _____

Date of Onset: _____ Surgery Date: _____

Please Circle: Chronic / Acute

Symptoms: _____

Work Related Injury: Y / N

Pain right now: 1 2 3 4 5 6 7 8 9 10 (1 = Minimal, 10 = Severe)

Pain at Best: 1 2 3 4 5 6 7 8 9 10 Pain at Worst: 1 2 3 4 5 6 7 8 9 10

Type of Pain: Aching / Tingling / Numbness / Sharp / Dull / Constant / Burning

Other: _____

What activity increases pain: _____

What activity decreases pain: _____

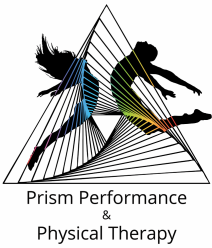
Have you had any imaging for this condition: _____

Are you currently taking any medications: _____

Have you recently experienced any of the following:

<input type="checkbox"/> Numbness	<input type="checkbox"/> Weight loss	<input type="checkbox"/> Leg pain
<input type="checkbox"/> Tingling	<input type="checkbox"/> Weight gain	<input type="checkbox"/> Fever
<input type="checkbox"/> Weakness	<input type="checkbox"/> Headaches	<input type="checkbox"/> Chills
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Leg cramping	<input type="checkbox"/> Vision change

Other: _____



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Do you currently have or have you ever been diagnosed with any of the following:

<input type="checkbox"/> Cancer	<input type="checkbox"/> Asthma	<input type="checkbox"/> Surgeries
<input type="checkbox"/> Heart problems	<input type="checkbox"/> Lung disease	<input type="checkbox"/> Fainting
<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Allergies	<input type="checkbox"/> Stroke
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Blood Pressure problems	<input type="checkbox"/> Leg swelling
<input type="checkbox"/> Seizures		<input type="checkbox"/> Circulation problems
<input type="checkbox"/> Other		

If checked above, please explain: _____

Treatment Goals

What do you hope to accomplish with your treatment: _____

Are there any other questions or concerns you would like to ask your physical therapist: _____

Patient printed name: _____

Patient or parent/guardian signature: _____