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:

☐ Numbness	☐ Weight loss	☐ Leg pain
☐ Tingling	☐ Weight gain	☐ Fever
☐ Weakness	☐ Headaches	☐ Chills
☐ Fatigue	☐ Leg cramping	☐ Vision change

Other:_____

Prism Performance
&
Physical Therapy

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

☐ Cancer	☐ Asthma	☐ Surgeries
☐ Heart problems	☐ Lung disease	☐ Fainting
☐ Pacemaker	☐ Allergies	☐ Stroke
☐ Diabetes	☐ Blood Pressure problems	☐ Leg swelling
☐ Seizures		☐ Circulation problems
☐ 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:_____