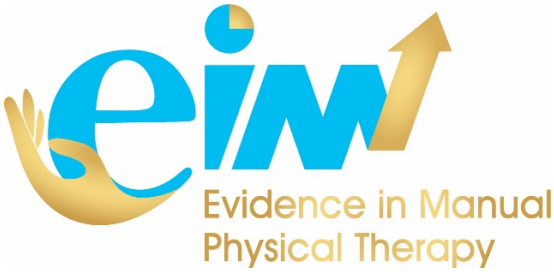

NEW PATIENT INTAKE FORM

Date:_____

Last Name:	First Name:
Address:	Apt. or P.O. Box:
City:	State:
Zip Code:	Date of Birth:
Phone Numbers	
Home Phone: ( )	Email:
Work Phone: ( )	Social Security Number:
Cell Phone: ( )	

Emergency Contact

Last Name:	First Name:
Phone: ( )	
Relationship:	

Employer Information

Name of Employer:	
Address:	Suite or Office Number:
City:	State:
Zip Code:	

Problem/Condition

Description of Problem:	

Referred by:	
Referral Information:	
Date of Onset:	

Primary Insurance

Insurance:	ID Number:
Group Number:	Claim Number:
Deductible:	Max Annual Benefit:
Copay:	Coinsurance:
Subscriber Information	
Subscriber's Name:	Subscriber Relation to Patient: oSelf oSpouse oParent oOther
Subscriber's Date of Birth:	

Secondary Insurance

Insurance:	ID Number:
Group Number:	Claim Number:
Deductible:	Max Annual Benefit:
Copay:	Coinsurance:
Subscriber Information	
Subscriber's Name:	Subscriber Relation to Patient: oSelf oSpouse oParent oOther
Subscriber's Date of Birth:	

How did you hear about us?

Have you ever been treated at EIM PT ? *Yes* _____ *NO*

Have you had physical therapy, occupational therapy or chiropractic treatment this year? Yes No . If yes, please indicate the type of treatment and the duration of treatment?_____.

Have you previously had treatment for this condition? Yes No If yes, for how long?_____.

Have you ever had surgery? Yes No . If yes, please list all surgeries:_____.

For Medicare Patients Only:

MC # (from Medicare card):

Are you currently receiving home care services? **Yes NO** . If yes, expected date of Completion? _____.

Have you received Home health care services in the past 6 month? **Yes NO .**

Do you have a home care discharge letter? **Yes No .**

Are you or your spouse currently employed? **Yes No .**

Are you retired? **Yes No** ***if yes, retirement date:***

Are you covered by group health plan? **Yes No**

Name of the plan: contract number: .

Are you entitled to ESRD Benefits? Yes NO

Entitled to Black lung Benefits: Yes NO

Auto Accident: Yes NO

Workers compensation: Yes NO

For Athletes Only:

What sport(s) does the student athlete play?

Was the athlete injured during the performance of the sport? **Yes NO .**

If yes, what date was the athlete injured?

Was the athlete injured at school or in a league?

_____

Was any paperwork filed with the school or league? **Yes No .**

If yes, please provide the name of the sschool or the League:

_____

Motor Vehicle Accident Injuries Only:

If you are receiving care for injuries from a motor vehicle accident, in what state did the accident occur? _____.

Address:

_____

Are you filling a lawsuit or do you intend to in the future?

_____

If yes, who is the responsible party?

_____

Attorney name and phone number:

_____

Slip and Fall ? Yes No liability? YES NO .

Primary Care Physician: _____Phone number:_____.

Date of 1st Doctors Visit for this Injury:_____

Last Day Worked Due to this Injury
(if applicable):_____

Date Returned to Work after Injury
(if applicable):_____

Referral Source: Surgeon Rehab MD

Other:_____

Have you had Surgery for this Injury? YES NO

Number of Surgeries and type: _____
_____

Are you currently taking any medications (prescription and/or over the counter medicines):

Anti-Inflammatories YES NO If YES, please specify:
_____

Muscle Relaxers YES NO If YES, please specify:
_____

Pain Medication YES NO If YES, please specify:
_____

Other YES NO If YES, please specify:
_____

Have you had any of the following diagnostic, medical or rehabilitative services for this injury/episode?

	YES	NO		YES	NO
Chiropractor	____	____	General Practitioner	____	____
EMG/NCV	____	____	CT Scan	____	____
Massage Therapy	____	____	MRI	____	____
Myelogram	____	____	Neurologist	____	____
Occupational Therapy	____	____	Orthopedist	____	____
Physical Therapy	____	____	Podiatrist	____	____
Emergency Room	____	____	X-Rays	____	____

Do you now or have you ever had any of the following?

	YES	NO		YES	NO
Asthma, Bronchitis, or Emphysema	____	____	High Blood Pressure	____	____
Anemia	____	____	Shortness of Breath/Chest Pain	____	____
Heart Attack or Surgery	____	____	Diabetes	____	____
Coronary Heart Disease or Angina	____	____	Thyroid Trouble/Goiter	____	____
Gout	____	____	Cancer/chemotherapy/Radiation	____	____
Dizziness or Fainting	____	____	Weakness	____	____
Emotional/Psychological Problems	____	____	Infectious Diseases	____	____
Hernia	____	____	Bowel or Bladder Problems	____	____
Numbness or Tingling	____	____	Allergies	____	____
Severe or Frequent Headaches	____	____	Elbow/Hand Injury	____	___
Neck Injury/Surgery	____	____	Stroke/TIA	____	____
Sleeping Problems/Difficulties	____	____	Back Injury/Surgery	____	____
Blood Clot/Emboli	____	____	Leg/Ankle/Foot Injury/Surgery	____	____
Knee Injury/Surgery	____	____	Epilepsy/Seizures	____	____
Do you have a Pacemaker?	____	____	Arthritis/Swollen Joints	____	____
Varicose Veins	____	____	Any Pins or Metal Implants	____	____
Are You Pregnant?	____	____	Joint Replacement	____	____
Weight Loss/Energy Loss	____	____	Do You Smoke?	____	____
Rheumatoid arthritis	____	____	GI problems	____	____
Ligaments laxity	____	____	recent bone scan date	____	____
Osteoporosis	____	____	Recent Falls	____	____

Over the past 2 weeks, how often have you been bothered by any of the following problems?

1-little interest or pleasure in doing things	____	____
2-Feeling down, depressed or hopeless	____	____

Please list any additional information that would assist us in providing care to you?

_____

_____

_____

Are you aware of your diagnosis (what you are being treated for at our clinic)?

Yes No

What are your expectations/goals?

_____
_____
_____

By my signature below, I certify that the information I have provided above is complete, accurate and truthful to the best of my knowledge.

Patient/Legal Guardian Signature: _____ Date: _____

Therapist's Signature:_____ Date: _____

Patient's Name: _____ Date: _____

Please list all your medications, including all prescriptions, over the counter medications, herbals, vitamins, minerals, and dietary supplements, and the dosage, frequency and administration method for each medication.

Medication	Dosage	Frequency	Method of Administration
		q As Needed q Once daily q Twice daily q Three times daily q Other:	q Oral q Sublingual q Topical q Subcutaneous injection q Other:
		q As Needed q Once daily q Twice daily q Three times daily q Other:	q Oral q Sublingual q Topical q Subcutaneous injection q Other:
		q As Needed q Once daily q Twice daily q Three times daily q Other:	q Oral q Sublingual q Topical q Subcutaneous injection q Other:

		q As Needed q Once daily q Twice daily q Three times daily q Other:	q Oral q Sublingual q Topical q Subcutaneous injection q Other:
		q As Needed q Once daily q Twice daily q Three times daily q Other:	q Oral q Sublingual q Topical q Subcutaneous injection q Other:
		q As Needed q Once daily q Twice daily q Three times daily q Other:	q Oral q Sublingual q Topical q Subcutaneous injection q Other:
		q As Needed q Once daily q Twice daily q Three times daily q Other:	q Oral q Sublingual q Topical q Subcutaneous injection q Other:
		q As Needed q Once daily q Twice daily q Three times daily q Other:	q Oral q Sublingual q Topical q Subcutaneous injection q Other:
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		q As Needed q Once daily q Twice daily q Three times daily q Other:	q Oral q Sublingual q Topical q Subcutaneous injection q Other:

		q As Needed q Once daily q Twice daily q Three times daily q Other:	q Oral q Sublingual q Topical q Subcutaneous injection q Other:
		q As Needed q Once daily q Twice daily q Three times daily q Other:	q Oral q Injection q Other:

Newsletter:

□ I would like to receive Professional's Newsletter, which contains information about the company and its services.

CONSENT TO TREATMENT: I consent to receive rehabilitation therapy treatment and any supplementary services that are deemed medically necessary or appropriate by my therapist and/or treating physician. However, I understand that the practice of rehabilitation therapy is not an exact discipline and I acknowledge that no guarantees have been made to me regarding treatment and/or the treatment results from the rehabilitation therapy.

Signature of Patient or Legal Guardian: _____ Date:____/____/ _____