PATIENT INTAKE PROFILE

DATE: _____

NAME: _____

AGE: _____

SEX: **M** or **F**

NEXT PHYSICIAN VISIT: _____

How did you come to know about **Promotion Therapy Services?** *(Please check all that apply)*

____ Your doctor referred you

____ Your Case Manager referred you to us. *Name*:_____

____ A Friend or Relative referred you to us. *Name*: _____

____ Insurance Directory/Website referred you to us

____ You were a previous patient here

____ Location/saw our sign from the road

_____ Advertising

_____ Other

History

1. What is your chief complaint? _____
   _____
2. How did this begin? _____
   _____
3. When did this problem begin?
   _____
   _____
   If this began more than 6 weeks ago, what prompted you to see the doctor now?
   _____
4. Have you ever had a similar problem before? **Yes** or **No** If yes, please explain
   _____
   _____
5. Have you ever had any of the following conditions*?* *(Please circle all that apply)*

   Asthma Emphysema Cancer High Blood Pressure Arthritis Heart Problems Diabetes

Symptoms Information

6. What symptoms are you having? *(Please circle all that apply)*
   Pain Popping Swelling Aching Grating Cramps Catching Weakness Burning
   Tingling Giving out Locking Numbness Other_____

7. Is your pain? Constant _____ Intermittent_____
8. If your pain getting (circle one) Better Worse No Change
9. Rate your pain (circle one) **0= Best** **10= Worst** **0 1 2 3 4 5 6 7 8 9 10**

Previous Treatment

10. What tests have you done for this condition? (please circle all that apply)
    X-Rays EMG MRI CT Scan Myelogram Lab Tests
    Other: _____
11. List all surgeries:
    _____ Date:_____
    _____ Date: _____
    _____ Date:_____
12. Have you had any previous Physical Therapy? **YES** or **NO**
    If Yes, please explain _____
13. Are you currently under Chiropractic care? **YES** or **NO**
    If Yes, please explain _____
14. List current medications (*If you have a list, we can make a copy of that list)*

    _____ _____ _____
    _____ _____ _____
    _____ _____ _____

Activity Tolerance

15. Because of your injury/condition, throughout the day what do you notice you:

CANNOT DO	HAVE DIFFICULTY DOING
_____	_____
_____	_____
_____	_____

16. Please list your hobbies and/or interests _____
    _____
17. List all allergies to food, medication, other substances _____
    _____
18. What if your primary goal for treatment? _____
    _____

Thank you, this information is very important.

_____ _____
Patient Signature Therapist Signature