Peak Rehabilitation INC
PHYSICAL THERAPY

NEW PATIENT INTAKE FORM

Today's Date: _____

PATIENT INFORMATION

First Name	Middle Initial	Last Name	Preferred Name	Social Security Number

Address:	City:	State:	Zip Code:

Home Phone: Cell Phone:	Date of Birth (mm-dd-yyyy)	Sex: M F	Status: Single Married Divorced Separated Widowed Unknown

Date of Injury/Onset Date	Auto Accident Yes-State__ No	Work Related: Yes No	

PRIMARY INSURANCE

Name of Insurance Company:	Member ID:	Group #

Policy Holder Name:	Date of Birth:	Policy Holder SS#:

Policy Holder Employer:	Policy Holder's Contact Phone:	Patient Relationship to Policy Holder Self Spouse Dependent Other

GUARANTOR INFORMATION FOR MINOR PATIENT
(PARENT WHO BRINGS THE PATIENT FOR TREATMENT)

Parent Name:	Parent SS#:	Parent DOB:

Name of Employer:	Employer Phone:	Parent Cell:

PATIENT EMPLOYER INFORMATION

Employer Name:	Employer Phone:	Employment Status: None FT PT Self-Emp Retired Student	

Address:	City:	State:	Zip Code:

EMERGENCY CONTACT INFORMATION

Contact Name: Can We Speak to this Person? Yes No	Home Phone: Cell Phone:	Relationship Spouse Mother/Father Relative Friend

PHYSICIAN INFORMATION

Name of Referring Physician:	Telephone #	

Name of Primary Care Physician:	Telephone #	

Peak Rehabilitation INC
PHYSICAL THERAPY

PAST MEDICAL HISTORY FORM

Patient Name _____ **Date:** _____

Describe your current symptoms: _____

Have you had these symptoms before? ☐ Yes ☐ No

Check how the injury occurred:

☐ Work related injury
☐ Motor vehicle accident
☐ Unknown cause of injury
☐ Recurrence of previous injury
☐ Injury related to lifting
☐ Athletic/recreational injury
☐ Injury related to fall
☐ Surgery/Date_____

Do you have, or have had any of the following conditions?

	Yes	No		Yes	No
Diabetes	☐	☐	Allergy to Aspirin	☐	☐
Chest Pain/Angina	☐	☐	Allergy to heat	☐	☐
Heart disease	☐	☐	Allergy/poor tolerance cold	☐	☐
Heart attack	☐	☐	Other allergies _____	☐	☐
Heart palpitations	☐	☐	Hernia	☐	☐
Pacemaker	☐	☐	Seizures	☐	☐
Headaches	☐	☐	Metal Implants	☐	☐
Kidney problems	☐	☐	Dizziness/Fainting	☐	☐
Are you pregnant?	☐	☐	Recent Fractures	☐	☐
Cancer	☐	☐	Surgeries	☐	☐
Osteoporosis	☐	☐	Skin Abnormalities	☐	☐
Bowel/Bladder abnormalities	☐	☐	Sexual Dysfunction	☐	☐
Urine Leakage	☐	☐	Nausea/vomiting	☐	☐
Asthma/Breathing difficulties	☐	☐	Ringing in your ears	☐	☐
Liver/Gallbladder problems	☐	☐	Rheumatoid Arthritis	☐	☐
Smoking	☐	☐	Special diet guidelines	☐	☐
Other _____	☐	☐	Stroke/CVA	☐	☐

If you answered YES to any of the above, please explain briefly and give approximate date:

_____

_____

_____

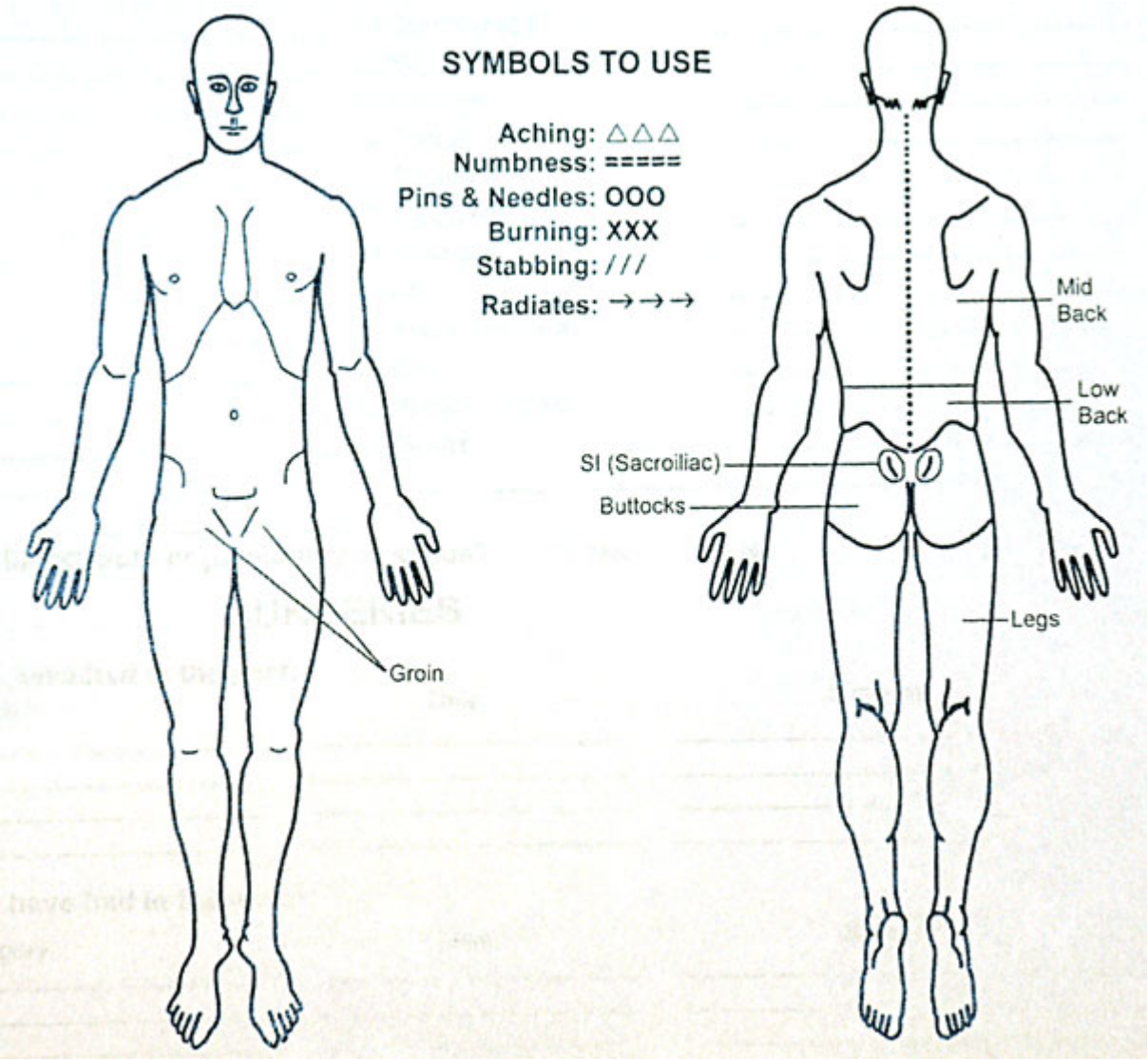
Are you presently taking Medication? ☐ Yes ☐ No

Please list name of medication with dosage:_____

_____

_____

If you are having pain, please rate the intensity on a scale of 0-10, with 0 being no pain and 10 being the worst pain: _____



_____ _____ _____

Patient Signature Parent Signature if patient is minor Date