Cornerstone Wellness Center

Patient Intake Form

Patient Information:

Last Name: ______________________ First Name: ______________________ Sex: ________

Date of Birth: ______________________ SS#: ______________________

Address: ________________________________ City: ______________________ State: _____

Zip Code: __________ Cell #: ( ) ______ - ________ Home #: ( ) ______ - ________

Email: ____ Work #: ( ) ______ - ______

Marital Status: Single_____ Married_____ Divorced_____ Widowed_____ Partnership____

Employer's Name: _________________________ Occupation: _________________________

Physician's Name: _________________________ Phone #: ( ) ______ - ________

Is your injury work related or auto related?: _________ Allergies: ________________________

Emergency Contact: _____________________________ Phone #: ( ) ______ - ________

Insurance Information:

Insurance Co Name: ________________________________ Policy #: ______________________

Address: ______________________________ City: ________________ State: _____ Zip: _____

Insured's Name: _______________________ SS#: ________________ Date of Birth: _________

Address: ______________________________ City: ________________ State: _____ Zip: _____

Insured's Employer's Name: ____

Patient Signature: _________________________________ Date: _________________________

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Patient History

Name: ___________________________ Date of Birth: ___________ Right or Left Handed: ____

What is your main complaint?:____

____

Rate your main complaint in order of severity from worst (10) to least (1): _____

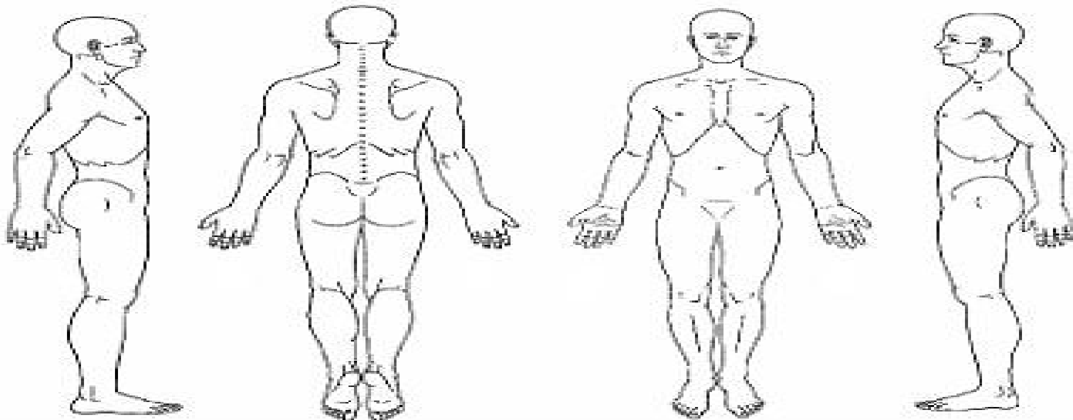
At it's worst: ____ At it's best: ____ Worse in the: ____ AM ____PM ____ Constant ____ Inconsistent

Are your symptoms: _____ Improving _____ Worse _____ Stable

Where is your main concern? Indicate on the body chart. Pain= x

Indicate the nature of your pain and symptoms?: ___ Sharp ___ Dull ___ Piercing ___ Shooting

___ Aching ___ Deep ___ Shooting ___ Tingling ___ Numbness ___ Intermittent ___Burning



When and how did this problem begin?: ____

What makes your symptoms/ pain worse?: ____

What makes your symptoms/ pain better?: ____

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Social History

Are you presently working? ______ Yes, _____ No, since _______________________________________

____

Physical/Emotional demands of present occupation? (High, Moderate, minimal) ____________________

____

Overall activity level: _____Sedentary _____ Light _____Moderate _____ Heavy _____Very Heavy

Sports and Exercise (Type, Frequency, Duration) ____

____

Use of Tobacco: _____ Yes _____ No Use of Alcohol: _____Yes _____ No # per week? ______

Family Medical History:

Does anyone in your immediate family (mother, father, siblings) have a history of Diabetes, High Blood Pressure, Cardiac Problems, or Cancer?

____

____

Please list 3 goals of Physical Therapy and time frames:

1) ____
2) ____
3) ____

Who can we thank for this referral?

____

Thank you for your patience and valuable time!!!

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Medical History

Do you exercise beyond daily activities: Days per week:_____ What type of exercise:_________________
Any major life changes in the past year: _____ Yes _____ No If yes, explain:
____
Do you have any allergies: _____Yes _____ No If yes, list: ___________________________________

Please check if you have ever had:

□Arthritis
□Broken bones
□Osteoporosis
□Blood disorders
□Heart problem
□High blood pressure
□Lung problem
□Stroke
□Diabetes
□Hypoglycemia (low blood sugar)
□Head injury
□Multiple Sclerosis
□Muscular dystrophy
□Parkinson's disease
□Seizures/epilepsy
□Allergies
□Thyroid problem
□Developmental (growth) problem
□Cancer
□Tuberculosis
□Hepatitis
□Kidney problems
□Repeated infections
□Ulcers/stomach problems
□Skin diseases
□Depression
□Pacemaker
□Fibromyalgia
□Hernia
□Migraines
□Concussion
□Asthma
□AIDS/HIV
□Anemia
□Appendicitis
□Circulation/vascular problems
□Other_______________

Within the past year have you had any of the following?

□Chest pain
□Difficulty sleeping
□Heart palpitations
□Loss of appetite
□Cough
□Nausea/vomiting
□Hoarseness
□Difficulty swallowing
□Shortness of breath
□Bowel problems
□Dizziness or blackouts
□Weight loss/gain
□Coordination problems
□Urinary problems
□Headaches
□Weakness in arms or legs
□Fever/chills/sweats
□Loss of balance
□Difficulty walking
□Hearing problems
□Joint pain or swelling
□Vision problems
□Pain at night
□ Other
Men: Prostate disease □Yes □No
Women: □Pelvic inflammatory disease □Endometriosis
□Trouble with your periods □Complicated pregnancy
□Currently pregnant
□Other_______________

Current Medications:
____
____
____
____
____
____
____
____
____

Surgeries (include year)
____
____
____
____
____
____
____
____
____

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Physical Therapy Consent From

Consent: I consent to and authorize Jennifer Leach PT, DPT and Jarrett Holmes, PTA to provide physical therapy services to me. I understand and am informed that, as in the practice of medicine, physical therapy may have some risks. I understand that I have the right to ask about these risks and have any questions about my conditions answered prior to treatment. I know it is up to me to inform the therapist about any health problems or allergies I have, as well as medications I am taking. It is also my responsibility to inform the therapist if I am uncomfortable during any given technique or treatment.

Minor Patients: The parent or guardian accompanying a minor is responsible for payment of services. Unaccompanied minors (under 18) cannot be given treatment, unless the parent or guardian has signed patient and financial responsibility forms.

Release of Information: I understand that no records will be transferred or information about my case can be shared with any other medical provider or entity without my specific request and authorization.

No Guarantees: I understand that the practice of physical therapy is not an exact science and that no guarantees have been made to me as a result of treatments or examinations by the physical therapist or supportive staff. I understand that no contract, guarantee, warranty, or promise concerning the results of the physical therapy services is made.

Payment: Cash, check, and credit card payments are accepted. We also accept Care Credit and HSA/FSA cards. Payment plans may be available. We are an out-of-network provider for all insurances. Insurance will be verified to determine if there are available benefits.

No Show/Cancellations/Late Fee Policy: Cancellations with less than 24 hour notice will result in a $25 fee.

Patient Name: ____

Patient Signature: ____

Date: ____