Three Trees Physical Therapy

285 Washington St, Suite 4, Easton MA 02356

p. 508-230-2323

**Intake Form** Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_

**Personal Data**

\*All fields below are required. Please confirm the information we have is correct, and either check the box to the right to confirm, or write in missing information/corrections/changes in the lines provided.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_ Sex: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City/State/Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ❑ Cell ❑ Home

Secondary phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ❑ Cell ❑ Home

Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent’s Names (if under 18 years old):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance Information**

Referred By:

Insurance: Member ID:

Is patient the primary insured? ❑ Yes ❑ No

 If no, name of primary insured:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**COVID-19 Screen**

Within the last 14 days, have you experienced any of the following symptoms?

Fever ❑ Yes ❑ No Shortness of breath ❑ Yes ❑ No

Cough ❑ Yes ❑ No Muscle aches ❑ Yes ❑ No

Fatigue ❑ Yes ❑ No Intestinal issues ❑ Yes ❑ No

*I hereby certify that the information provided is true and accurate.*

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_

**Reason for Today’s Visit (Please describe your chief complaint.)**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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When did this problem start? (if post surgical, date of surgery) \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had this problem before? ❑ Yes ❑ No

Is your injury related to a car accident? ❑ Yes ❑ No

Is your injury related to work? ❑ Yes ❑ No

Have you seen any of the following for your condition? ❑ Physical Therapist ❑ Chiropractor

 ❑ Orthopedic Surgeon

Has any imaging been done? ❑ Yes ❑ No

If imaging has been done, please describe what imaging (xrays, MRI, CT scan, etc.):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are your goals for physical therapy?

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Please indicate the location(s) of your pain on the diagram with XX marks:

● Please describe the pain:

 ❑ Dull ❑ Burning ❑ Numb ❑ Tingling ❑ Sharp

● How often does the pain occur?

 ❑ Constant ❑ Comes and Goes

● Does the pain radiate or travel? ❑ Yes ❑ No

● What makes the pain better? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

● What makes the pain worse? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

● Please indicate the severity of pain. Circle two numbers. The first number is how low the pain goes (when resting, taking meds, etc.). The second number is how high the pain goes when performing painful activities.

(0=no pain) 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 (10=worst pain ever)

● Please indicate what percent of normal function you feel you have currently.

(0% function) 0 – 10 – 20 – 30 – 40 – 50 – 60 – 70 – 80 – 90 – 100 (100% normal function)

**Patient Health History**

Please list all current medications, or submit as a separate list.

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Please list any allergies. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any past surgeries with dates.

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Please check off in the boxes below any health conditions which you had or currently have:’

 Yes Yes

AIDS/HIV positive ❑ Heart disease ❑

Angina ❑ Kidney problems ❑

Asthma ❑ Liver disease ❑

Arthritis ❑ Memory problems ❑

Artificial joint ❑ Mental/emotional disorders ❑

Balance problems ❑ Migraines ❑

Breathing problems ❑ Osteoporosis ❑

Cancer ❑ Pacemaker ❑

Chemotherapy ❑ Pain in jaw ❑

COPD ❑ Prostate problems ❑

Diabetes ❑ Radiation treatment ❑

Dizziness ❑ Recent weight loss ❑

Emphysema ❑ Rheumatoid arthritis ❑

Fatigue ❑ Seizures ❑

Gout ❑ Shingles ❑

Headaches ❑ Steroid use – long term ❑

Heart attack ❑ Stroke ❑

High/low blood pressure ❑ Swelling of limbs ❑

High cholesterol ❑ Thyroid disease ❑

Hepatitis ❑ Tuberculosis ❑

Other illness/conditions not listed above ❑

Please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Height: \_\_\_\_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_\_\_\_

*I hearby certify that the information provided is true and accurate.*

Patient Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_