Patient Demographics

Patient Name: ________________________________ Today's Date: ___________________________

Full Address: __________________________________ Date of Birth: __________________________

Home Phone: _________________________________ Age: __________________________________

Cell Phone: ___________________________________ SSN: __________________________________

Work Phone: __________________________________ Sex: M_______ F________

Primary Care Physician: ____

Emergency Contact Information

Name: _______________________________________ Relationship: ___________________________

Home Phone: _________________________________ Cell Phone: _____________________________

Is Your Injury Related to Any of the Following

An Auto Accident: Y______ N______ State Occurred in: _____________ Date of Accident: ___________

Auto Policy Holder: __________________________ Auto Insurance Claim Number _______________________

Work Related Injury: Y______ N______ State Occurred in: _____________ Date of Accident: ___________

Do you have an open claim: Y______ N______

If yes, Claim #: ___________________ Claim Manager: ____________________ Phone: __________________

Place of Employment: ___________________________ Full Address: ___________________________________

Therapy Intake Form

Name: _______________________________________ Today's Date: ___________________________

How did you find Maylath Therapy?

Physician Referral_____ Family_____ Newspaper_____ Website/Social Media_____ Other_____

History

Are you currently receiving any Home Health Services (if yes, explain): ___________________________________

Occupation: ________________________________ Employer____________________________________

Job Description: ____

Hobbies/Interests: ____

Are you Pregnant: Y_____ N_____ Do you have a pacemaker? Y_____ N_____

Allergies: _________________________ Latex Allergy: Y_____ N_____ Medical Tape Allergy: Y____ N____

Current Medications: ____

____

Past Surgeries: ____

____

Complaints

What is your major complaint: ____

Have you had an X-Ray, MRI, etc: Y_____ N_____ If yes, where: _________________________________

Have you had surgery: Y_____ N_____ If yes, date of surgery: _________________________

Possible Cause of Injury: ____

Symptoms: ____

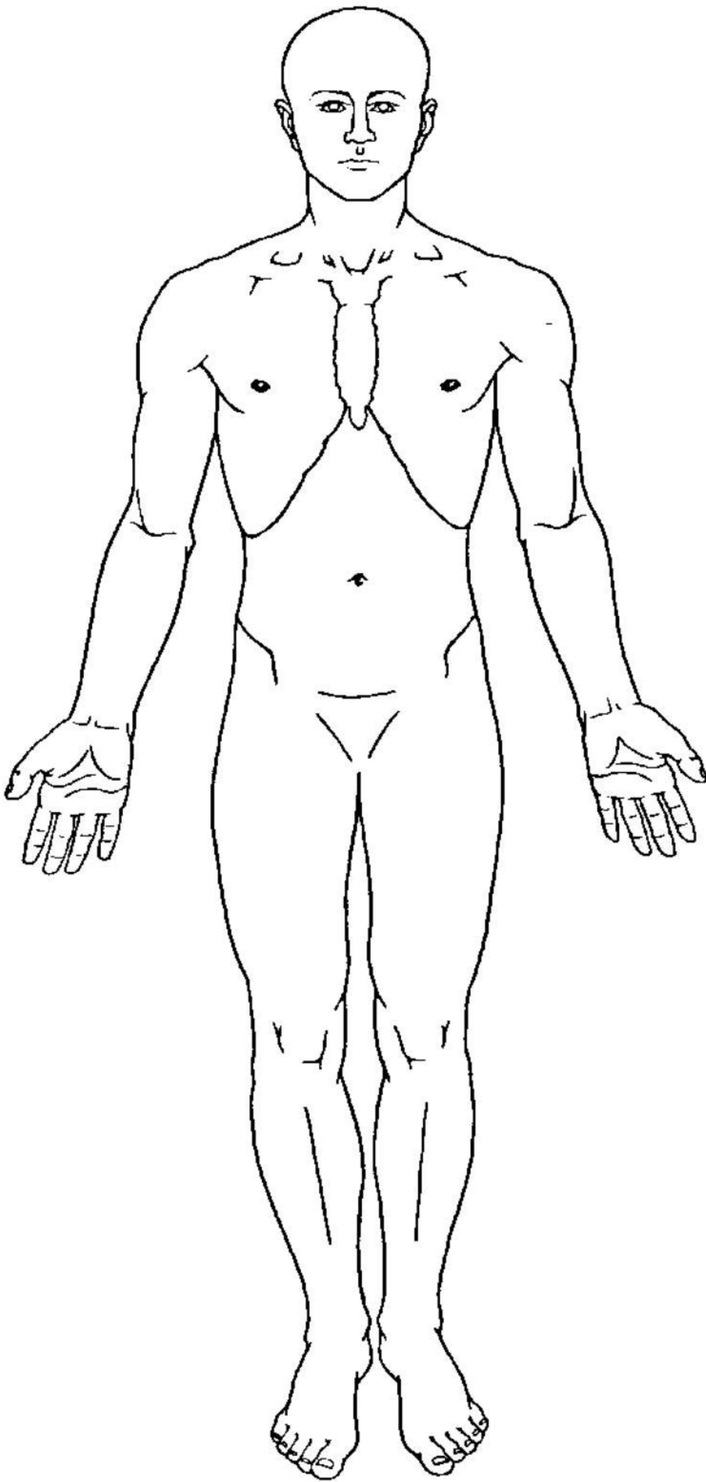
Previous Doctors Seen for Complaint: ____

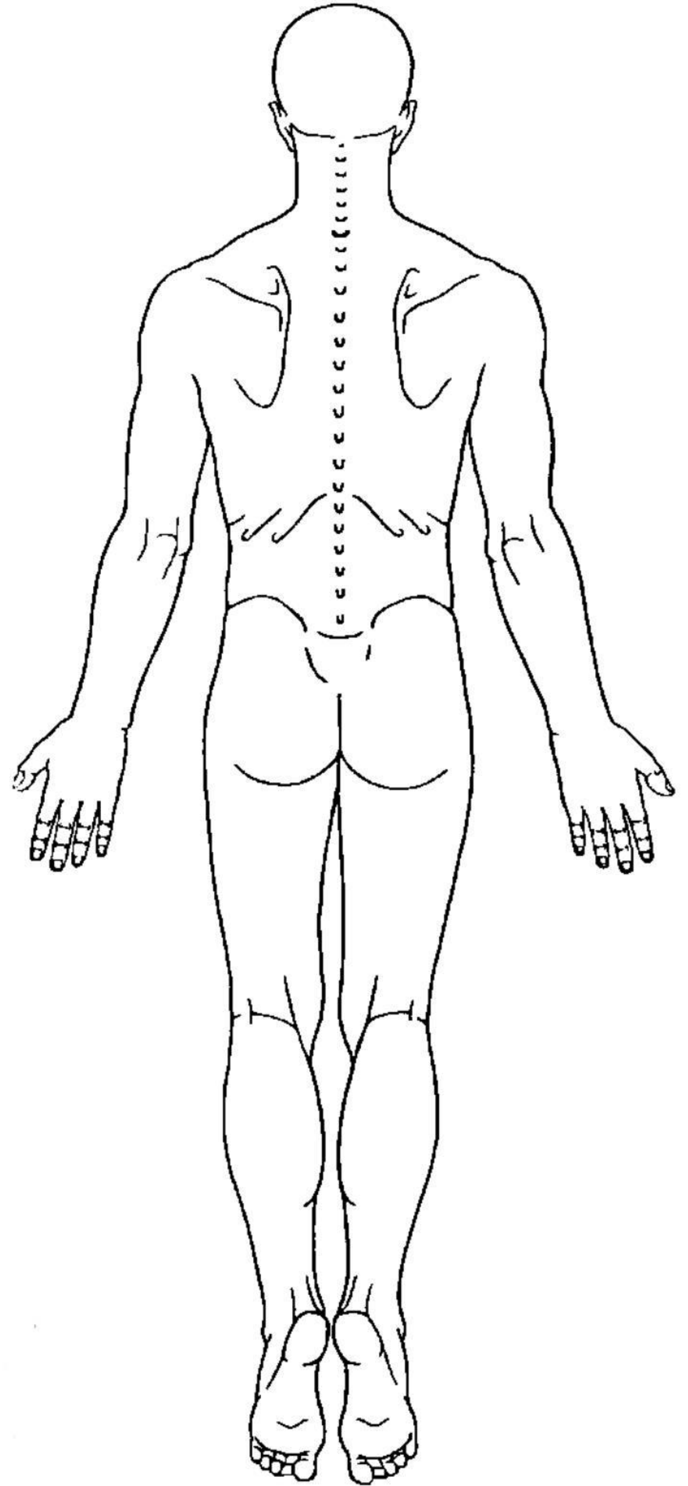
Previous Treatment of Complaint: ____

Medical History (Circle all that Apply)

Aids/HIV	Stroke	STD	Musculoskeletal Problems
Arthritis	Anemia	Angina	Tuberculosis
Cancer	Chemical Dependency	Blood Clots	Arteriosclerosis
Diabetes	Epilepsy	Circulation Problems	Depression
Hemophilia	High/Low Blood Pressure	Eye Infection	Heath Problems
Lung Issues	Multiple Sclerosis	Joint/Bone Infection	Liver Problems
Pneumonia	Urinary Infection	Other	

Mark Areas of Discomfort





Signature: ___________________________________ Date:____