Patient Demographics

Patient Name_____ Today's Date: ___/___/___

Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____

Work Phone:_____

Date of Birth: ___/___/___ Age:____ SSN:_____-_____-_____ Sex: M F

Emergency Contact Information:

Name:_____ Relationship:_____

Home Phone:_____ Cell Phone:_____

Is Your Injury Related to:

An Auto Accident: Yes No State Accident Occurred: _____

Date of Accident: ___/___/___

Auto Policy Holder:_____ Auto Insurance Claim#:_____

Is this a Work Related Injury: Yes No Date of Injury: ___/___/___

Do you have an open claim: Yes No

Claim #: _____ Claim Manager:_____

Phone:_____ Place of Employment:_____

Address:_____

City: _____ State: _____ Zip:_____

Physical Therapy Intake Form

Name:_____ Today's Date: ___/___/____

How did you find Maylath Therapy? ☐ Family ☐ Physican Referral ☐ Newspaper

☐ Website / Facebook ☐ Other:_____

History

Are you currently receiving any Home Health Services?_____

Occupation:_____ Employer:_____

Job Description:_____

Hobbies/Interests:_____

Are you pregnant? Yes No Do you have a pacemaker? Yes No

Allergies: _____

Latex: Yes No
Medical Tape: Yes No

Current medications:_____

_____

Past Surgeries:_____

_____

Complaint

What is your major complaint?_____

Have you had X-Ray or MRI, etc? Yes No If Yes, where?_____

Date of Injury:___/___/____ Date of Surgery:___/___/____

Possible Cause:_____

Symptoms:_____

Previous doctors seen for complaint:_____

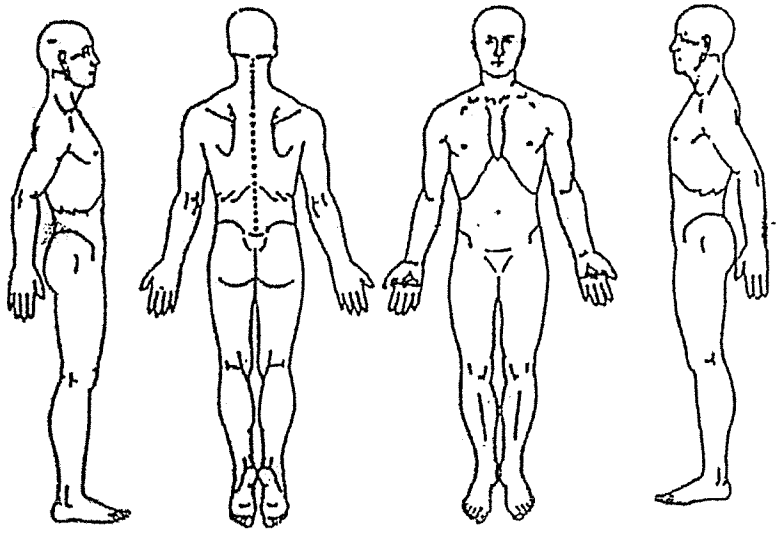
Previous treatment for complaint:_____

Physical Therapy Intake Form

Medical History (Check all that Apply)

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

Mark Areas of Discomfort



Signature_____ **Date:**____/____/____