

PATIENT INTAKE FORM

Name: _____ Date of Birth: _____ Today's Date: _____

Primary Phone: _____ Secondary Phone: _____

Email Address: _____

SpineScottsdale Physical Therapy will use your e-mail to send newsletters, appointment reminders, and other physical therapy related information. If you do not give your permission for this e-mail correspondence, please indicate on the E-mail Address line above.

Emergency Contact: _____ Phone Number: _____

How did you choose SpineScottsdale Physical Therapy? _____

Referring Physician: _____ Primary Care Physician: _____

Do you have a follow up appointment with your referring physician? No: _____, Yes: _____ (date) _____

Is this the result of an auto accident?: _____ No _____ Yes, date: _____ State where occurred: _____

**If yes, please provide our front office with auto insurance claim information

HISTORY

Location of present symptoms: (please indicate on diagram) →

Date of Injury or Onset of Symptoms: _____

Cause of injury: _____ or no apparent reason: _____

Frequency of your symptoms (circle best response):

- Constant (always there 24 hours per day)
- Intermittent (symptoms fluctuate based on position or how you are moving)
- Indicate what percent of day you notice your symptoms.

25% of day 50% of day 75% of day 100% of day

What **increases** your symptoms (circle all that apply):

Bending Sitting Sit to stand Standing Walking Lying Sleeping Turning head

A.M. / as the day progresses / P.M. When still / On the move Other: _____

What **decreases** your symptoms (circle all that apply):

Bending Sitting Sit to stand Standing Walking Lying Sleeping Turning head

A.M. / as the day progresses / P.M. When still / On the move Other: _____

Intensity of your symptoms: On a scale of 0 to 10, 0 meaning no pain and 10 meaning worst possible pain, please circle the number that best describes your symptoms:



Previous treatment for this condition: _____



