The Total Joint
PHYSICAL THERAPY

Patient Intake Information

Demographics:

First Name:_____ Middle Initial:_____ Last Name:_____

Preferred Name:_____ Pronouns:_____

Gender:____ DOB: _____ SSN:_____ Email:_____

Home Phone:_____ Cell Phone:_____

Address:_____ City, State, ZIP:_____

Emergency Contact: _____ Emergency Contact #:_____

Injury Information:

Cause of Injury/Symptoms: ☐ Fall ☐ Sports/Recreation ☐ Chronic Condition
☐ Car Accident ☐ No Known Cause ☐ Other:_____

Date Symptoms Began:_____ Symptom Location:_____

Other Treatment:_____

Is there an attorney involved? ☐ Yes ☐ No

Attorney Name:_____ Attorney Phone #:_____

Medical History:

Please list your current medications (name, dosage):_____

_____

_____

Do you have/have a history of:

☐ Heart Disease	☐ Stroke/TIA	☐ High Blood Pressure	☐ High Cholesterol
☐ Falls	☐ Depression/Anxiety	☐ Pacemaker/Defibrillator	☐ TBI
☐ Diabetes	☐ Arthritis	☐ Tobacco Use	☐ Pregnancy
☐ HIV	☐ Blood Clots	☐ Cancer (Type:_____)	☐ Osteoporosis

Please list all relevant surgeries/dates:_____

_____

Referral Information:

Do you have a referral? ☐ Yes ☐ No

Referring Physician:_____Phone #:_____

How Did You Find Us?: ☐ Referral from Doctor/Medical Professional ☐ Referral from Friend
☐ Google Search ☐ Social Media Ad ☐ Other:_____

Patient Signature:_____ Date:_____