



Please complete this intake form and print clearly so we may transfer your information to our medical database for proper claim submission.

The privacy and security of your personal health information is very important to us.

We will do our best to answer your questions in a professional and private manner.

Thank you for trusting us with your health care.

PATIENT INFORMATION

Today's Date: ____/____/____ Date of Birth: ____/____/____

Last Name: _____ First: _____ MI: _____ Nickname: _____

Address: _____ City: _____ State: _____ ZIP: _____

E-mail address: _____

Sex: Male Female Status: Minor Single Married Divorced Widowed

Driver's License Number: _____ State: _____ SS#: _____ - _____ - _____

Employer: _____ Occupation: _____

Address: _____ City: _____ State: _____ ZIP: _____

Work Related Injury?: Yes No Auto Related Injury?: Yes No Date of Injury: ____/____/____

How did you hear about Naperville Physical Therapy Center? Physician Insurance Friend/Relative Other

Whom may we thank for referring you? _____

In case of emergency, who should be notified? Name: _____ Relationship: _____ Phone: () _____ - _____

PREVIOUS ADDRESS IF LESS THAN TWO YEARS AT PRESENT ADDRESS

Address: _____ City: _____ State: _____ ZIP: _____

INSURANCE – Who is responsible for this account? If same as above you may leave blank. Please have your insurance card available for us to make a copy.

Insured Name: _____ Relationship to Patient: _____

Address: _____ City: _____ State: _____ ZIP: _____

SS#: _____ - _____ - _____ Date of Birth: ____/____/____



Name: _____ Age: _____

To assist your therapist in providing optimal rehabilitative care, please complete all the questions below:

DO YOU HAVE, OR HAVE YOU EVER HAD, ANY OF THE FOLLOWING:

	YES	NO		YES	NO
Diabetes			Chronic Headaches		
High/Low Blood Pressure			Dizziness		
Heart Disease			Vertigo		
Chest Pain			Seizures		
Pacemaker			Kidney Problems		
Shortness of Breath			Liver Problems		
Chronic Cough			Abdominal Pain		
Wheezing			Pregnancy		
Asthma			Thyroid Condition		
Do You Smoke			Metal Implants, Pins, Plates, Shrapnel, Spinal Stimulator		
Excessive Weight Loss			Fractures		
Change in Urination			Fibromyalgia		
Change in Bowel Habits			Hernia (list type)		
Cancer			Previous Therapy		

If you answered **YES** to any of the above, please explain and give appropriate dates:

Do you have any allergies to: ڦ Heat/Cold ڦ Latex ڦ Massage Cream/Lotion
 Other allergies: _____

Are you presently taking medication?: ڦ YES ڦ NO
 If **YES**, please list what medication(s) and for what condition(s):
 (Use additional space on back of form)

Have you recently experienced fever, weight loss or loss of appetite: ڦ YES ڦ NO
 Are you involved in litigation?: ڦ YES ڦ NO
 What are your goals for physical therapy?:
