PATIENT INTAKE FORM

5767 W. Maple Road, Suite 400 West Bloomfield, MI 48322
Phone: 248-862-2851, Fax: 248-247-1290, Email: info@westbloompt.com

PATIENT INFORMATION PROFILE:

Patient Name (Last, First, Middle):		
Address City/State/Zip:		
Home Phone:	Cell Phone:	E-mail:
DOB:	Social Security#	Sex: ☐ Male ☐ Female
Primary Care Doctor:		
Referring Physician:		
Prescription Date/Frequency/Duration:		
Injured Body Part/Diagnosis:		
Emergency Contact Name:		
Emergency Contact Work/Cell Phone:		
Emergency Contact Relationship to Patient:		
Patients Place of employment:		

MEDICAL HISTORY FORM

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What body part are you here for?

When did your condition start? Give specific date of injury or onset:

Have you had previous physical therapy for this condition? ☐ Yes ☐ No

Have you had surgery recently? ☐ Yes ☐ No | If yes, what type of surgery?

Have you undergone any recent tests? ☐ X-Ray ☐ MRI ☐ CT ☐ EMG ☐ Other:

ARE YOU CURRENTLY EXPERIENCING OR HAVE YOU EXPERIENCED ANY OF THE FOLLOWING?

- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Heart Attack
- ☐ Pacemaker
- ☐ Heart Murmur/Arrhythmia
- ☐ Stroke
- ☐ Shortness of Breath
- ☐ Asthma
- ☐ Cancer
- ☐ Thyroid Problems
- ☐ Kidney Problems
- ☐ Infectious Disease/HIV/Hepatitis
- ☐ Pregnant/IUD
- ☐ Hernia
- ☐ Nervous Disorders/Depression
- ☐ Seizure
- ☐ Allergies/Skin
- ☐ Headaches/Dizziness
- ☐ Metal Implants
- ☐ Recent Fatigue/Weakness
- ☐ Recent Fever
- ☐ Recent Chills/Sweats
- ☐ Recent Weight Gainor Loss
- ☐ Injured in a Motor Vehicle Accident
- ☐ Any Previous Injury
- ☐ Previous Surgery

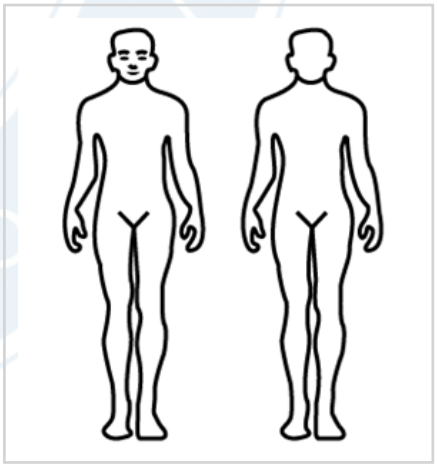
If YES on any of the above, please give details and approximate dates:

Are you currently taking any MEDICATIONS? ☐ Yes ☐ No

Please List:

Do you have PAIN? ☐ Yes ☐ No

If so, CIRCLE on the BODY CHART where you pain is located →



What does your pain feel like?

☐ Sharp ☐ Burning ☐ Aching ☐ Tingling ☐ Numbness
☐ Other: _____

Does pain radiate to arms and/or legs? ☐ Yes ☐ No

Rate your pain on a 0-10 scale (0=None, 10=Severe)

0 1 2 3 4 5 6 7 8 9 8

Does your pain awaken you at night? ☐ Yes ☐ No

If so, how many times each night? _____

What makes the pain WORSE?

☐ Lying Down ☐ Sitting ☐ Standing ☐ Walking ☐ Other: _____

INSURANCE & INJURY INFORMATION

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INJURY INFORMATION:

Is condition surgery related? ☐ Yes ☐ No	Date of surgery:
Surgical procedure:	
Is condition accident related? ☐ Yes ☐ No	Was an automobile involved? ☐ Yes ☐ No
Date of accident:	Were you the: ☐ Driver ☐ Passenger ☐ Pedestrian
Were you injured on the job? ☐ Yes ☐ No	Date of injury (Job):
Name City/State/Zip of employer at time of accident:	
Is litigation involved? ☐ Yes ☐ No	Name of attorney/adjuster:

INSURANCE INFORMATION:

Primary insurance:	
Subscriber Name:	Sex: ☐ Male ☐ Female
Date of birth:	
Relationship to Patient:	
ID card# # (including alpha prefix):	
Group#	Claim#
Secondary insurance:	
Subscriber Name:	Sex: ☐ Male ☐ Female
Date of birth:	
Relationship to patient:	
ID card# (including alpha prefix):	
Group#	Claim#

I CERTIFY THAT THE ABOVE INFORMATION IS ACCURATE.

PATIENT'S SIGNATURE: _____ **DATE:** _____