EVOLVE Physical Therapy
Intake & Medical History Form

Date: _____/_____/_____

Name: _____ **Date of Birth**: _____/_____/_____ **OK to leave messages (Y/N)?**: ____ Phone ____Email

Phone #(s): home/cell/work_____ **Email Address**: _____

Address: _____**City**_____**State**_____**Zip**_____

Height: _____ Weight: _____ **Marital status**: Married Single Other **Employment Status**: Full-Time Part-Time Student Retired Other

Employer: _____**Insurance Company**: _____ (For informational purposes only)

Emergency Contact Name and Phone #:_____

Primary Care Physician: _____ **PH#**_____ **Specialty Physician**: _____ **PH#**_____

CURRENT CONDITION

Current Complaint/Injury: _____ **Date of Onset**: _____

Current Symptoms: _____ **Condition (circle):** New Acute Chronic Recurring **Injury work or auto accident related**: Y or N

Previous treatment for current injury: _____ **Pain Level (0-10):** _____

Previous diagnostics tests for injury? (MRI, X-rays, labs, etc.)_____ **Results**: _____

MEDICAL HISTORY

Allergies: _____ **Latex Sensitive**: Y or N

Medications/Supplements: _____

Surgeries/hospitalizations: _____

Do you have EVER been diagnosed with any of the following? (Describe below if needed)

	YES	NO		YES	NO
Asthma	____	____	Arthritis	____	____
Emphysema/COPD	____	____	Osteoporosis	____	____
Coronary Heart Disease	____	____	Circulation/Vascular Disorder	____	____
Cardiac Pacemaker	____	____	Gout	____	____
High Blood Pressure	____	____	Anxiety/Depression	____	____
High Cholesterol	____	____	Emotional/Psychological Problems	____	____
Heart Attack/Surgery	____	____	Kidney/Liver Disease	____	____
Stroke/TIA	____	____	Severe/Frequent Headaches	____	____
Blood Clot/Emboli	____	____	Vision/Hearing Difficulties	____	____
Epilepsy/Seizures	____	____	Metal/Surgical Implants	____	____
Neurologic Disorder	____	____	Joint Replacements	____	____
Thyroid Disease/Goiter	____	____	Fractures	____	____
Anemia	____	____	Concussion/head injury	____	____
Infectious Disease	____	____	Alzheimer's/Dementia	____	____
(HIV, Tuberculosis, Hepatitis)			Drug or Alcohol Dependency	____	____
Diabetes	____	____	Are you pregnant?	____	____
Cancer or Chemo/Radiation	____	____			
Autoimmune Disorder	____	____			
Fibromyalgia	____	____			

Explain YES questions (if needed): _____

Have you RECENTLY experienced any of these symptoms? (Describe below if needed)

	YES	NO		YES	NO
Shortness of Breath	____	____	Nausea/Vomiting	____	____
Chest Pain	____	____	Fever/Chills/Sweats	____	____
Dizziness or Faintness	____	____	Bowel/Bladder Changes	____	____
Weight loss/gain	____	____	Night Pain	____	____
Numbness or Tingling	____	____	Joint pain/swelling	____	____
Sleeping Difficulties	____	____	Loss of balance/coordination	____	____

Explain YES questions (if needed): _____

Other Conditions/Symptoms: _____

SOCIAL & HEALTH HABITS

Exercise: Type: _____ Frequency: _____ Time/week Duration:_____ Minutes

Leisure/Hobby Activities: _____

Exercise: Type: _____ Frequency: _____ Time/week Duration:_____ Minutes

Smoking Daily _____ Weekly _____ **Alcohol Consumption**: Daily _____ Weekly _____

Number of Caffeinated beverages per day: _____ **Ounces of water per day**: _____

Are you aware of your Diagnosis? YES ___ NO ___ **Are you aware of your Prognosis?** YES ___ NO ___

Personal Goals for Physical Therapy: _____

CONSENT TO TREAT:

I hereby agree and give my consent to medical treatment in treating my physical condition. The signature below authorizes EVOLVE Physical Therapy to perform physical therapy services based on the medical history provided above. By signing below, I agree that all information provided is complete and accurate. I understand that I am responsible for all charges on a cash-based payment basis with full payment due at the time of service. I acknowledge my insurance company is not being billed for any physical therapy provided by EVOLVE Physical Therapy. (Medicare beneficiaries – please see below.) I acknowledge that I have received the "Notice of Privacy Practices". I understand that I may ask questions about the "Notice of Privacy Practices" at any time.

This form must be completed in its entirety and reviewed by EVOLVE Physical Therapy prior to treatment.

XPatient/Parent/Guardian Signature: _____ Date:_____

MEDICARE PATIENTS:

The only exception for insurance billing at EVOLVE Physical Therapy is patients who have Medicare insurance as their primary insurance. As a Medicare beneficiary, I consent to Medicare and any supplemental insurance plans being billed for PT services. I assign all my rights and claims for reimbursement under my Medicare (primary) and any supplemental (secondary) health insurance policies to be paid directly to EVOLVE Physical Therapy. I agree to provide information as needed to establish my eligibility for such benefits. I understand that insurance may not pay for all the services I receive and that I am responsible to pay for services provided to me that are not paid by insurance at a cash-based payment rate.

XPatient/Parent/Guardian Signature: _____ Date:_____

XReviewed by Physical Therapist: _____ Date:_____