FOLEY PHYSICAL THERAPY

PATIENT INTAKE

Name _____ Birth Date _____

Address _____

City _____ State _____ Zip _____

Preferred Phone Number _____

☐ Home ☐ Mobile

If Mobile, May I Text You? ☐ Yes ☐ No

Email Address _____

(Optional) Preferred Pronouns _____

Emergency Contact Person _____ Phone _____

Referring or Primary Care Physician _____

How Did You Learn About Foley Physical Therapy? _____

HIPAA Notice of Privacy Practices

I understand that Foley Physical Therapy will make every effort to keep my protected health information confidential and private. I understand that Foley Physical Therapy may use and disclose my protected health information for treatment and for related health care operations. I acknowledge that the Foley Physical Therapy Notice of Privacy Practices was made available to me.

X _____ _____

Patient Signature Date

Consent for Treatment of a Minor Patient

In the event that I am unable to accompany my minor child (under 18 years of age) to his/her Foley Physical Therapy appointments, I permit Foley Physical Therapy to render treatment to my child while I am not present.

X _____ _____

Parent or Guardian Signature Date

FOLEY PHYSICAL THERAPY

MEDICAL HISTORY

Name _____ **Date** _____

PAST HISTORY

Have you had any of the following?

☐ High blood pressure	☐ Heart condition	☐ Stroke	☐ Osteoporosis
☐ Peripheral neuropathy	☐ Seizures/epilepsy	☐ Vision problems	☐ Diabetes
☐ Frequent/severe headaches	☐ Fainting/dizziness	☐ Emphysema	☐ Cancer
☐ Bowel/bladder problems	☐ Hearing problems	☐ Arthritis	☐ Asthma

☐ Other _____

Have you had a fall in the past year?	YES	NO	-	If yes, how many? _____
Do you have a history of fractures?	YES	NO	-	Where? _____
Do you have a metal implant?	YES	NO	-	Where? _____
Do you smoke?	YES	NO	-	How much per day? _____
Do you exercise regularly?	YES	NO	-	How often? _____
Do you have any allergies?	YES	NO	-	Please list _____
Are you or may you be pregnant?	YES	NO		

Surgeries

_____ Date _____

_____ Date _____

CURRENT CONDITION

What is the problem to be treated? _____

Have you had similar symptoms before? _____

Have you had previous treatment for this condition? _____

Diagnostic Tests

Please check any tests or procedures that have been done for your current condition

☐ X-rays	☐ MRI	☐ CT scan	☐ Bone scan
☐ EMG	☐ Blood work	☐ Bone density	☐ Ultrasound

Medications

List the medications (prescribed or over the counter) or supplements that you are taking

_____

_____

Patient Pain Drawing

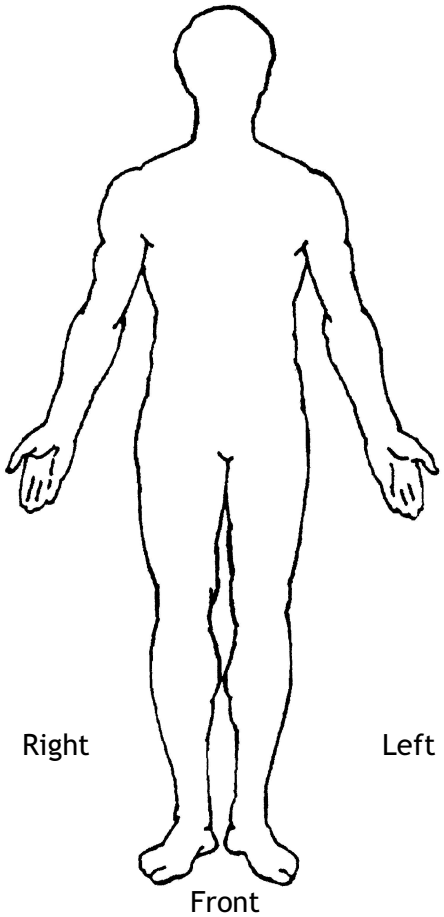
_____ _____

Name Date

Where is your pain now?

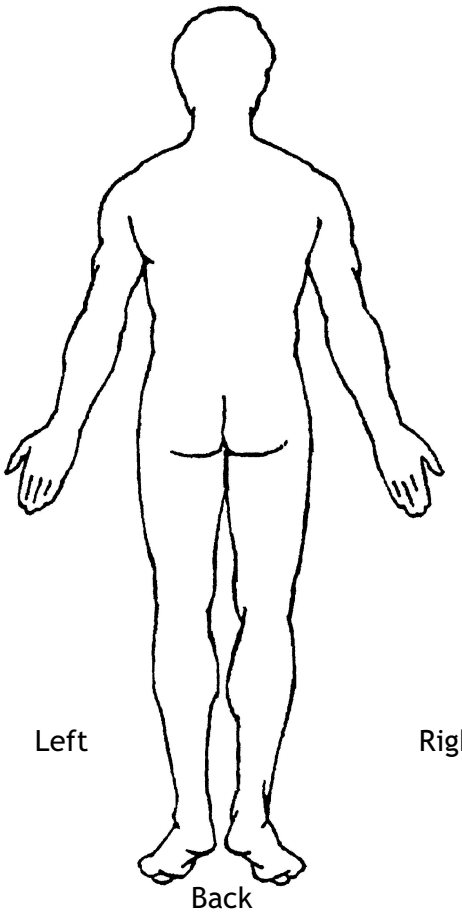
- Mark the areas on your body where you feel the sensations described below, using the appropriate symbol.
- Mark the areas of radiation.
- Include all affected areas.
- [redacted]

Aching	Numbness	Pins and needles	Burning	Stabbing
▲ ▲ ▲	= = =	○ ○ ○	× × ×	/ / /



Right Left

Front



Left Right

Back

How bad is your pain now?

- Please mark with an X on the body form where the pain is worst now.
- Please mark on the line how bad your pain is now:

No pain _____ Worst possible pain