Stretch™
Physical Therapy & Total Wellness

Massage/Wellness Intake Information

PATIENT INFORMATION

Name_____ Social Security Number_____

Address_____ City & Zip Code_____

Home Phone # _____ Cell Phone # _____ Birth Date _____ Age_____

Email Address _____ Text/Email Reminder_____

Sex_____ Marital Status _____

Spouse's Name & Phone # _____

Responsible Person's Name, Address & Phone # (for patients under 18)
_____

Primary Care Physician _____
Referring Physician _____
Employer Name _____ Phone Number _____
Address _____ Occupation _____

Have you had physical therapy or chiropractic care this calendar year? _____
How did you hear about us? _____ Doctor _____ Advertisement
_____ Friend (provide name) _____

The following signatures are mandatory prior to receiving treatment:

1. My signature indicates that I was provided, understand, and accept the policies described in the "Release and Waiver of Liability" document:

_____

2. My signature indicates that I was provided, understand, and accept the policies described in the “Statement of Privacy Notice” document.

_____

3. My signature indicates that I was provided, understand, and accept the policies described in the “General Policies, Informed Consent, and Assignment of Benefits: document.

_____

MEDICAL HISTORY

Patient Name: _____ Date: _____

Medical History: Are you currently experiencing or have you had any of the following:

Allergies	Y/N	Dizzy Spells	Y/N	MRSA	Y/N
Anemia	Y/N	Emphysema/Bronchitis	Y/N	Multiple Sclerosis	Y/N
Anxiety	Y/N	Fibromyalgia	Y/N	Muscular Disease	Y/N
Arthritis	Y/N	Fractures	Y/N	Osteoporosis	Y/N
Parkinson’s	Y/N	Gallbladder Problems	Y/N	Headaches	Y/N
Cancer	Y/N	Autoimmune Disorder	Y/N	Seizures	Y/N
Hepatitis	Y/N	Rheumatoid Arthritis	Y/N	Smoking	Y/N
HIV/AIDS	Y/N	Hearing Impairment	Y/N	Stroke	Y/N
Cardiac Conditions	Y/N	Cardiac Pacemaker	Y/N	High Cholesterol	Y/N
Speech Problems	Y/N	Chemical Dependency	Y/N	High/Low BP	Y/N
Circulation Problems	Y/N	Thyroid Disease	Y/N	Currently Pregnant	Y/N
Incontinence	Y/N	Tuberculosis	Y/N	Depression	Y/N
Kidney Problems	Y/N	Vision Problems	Y/N	Diabetes	Y/N
Metal Implants	Y/N				

PRESENT INJURY/PROBLEM

What is your current complaint? _____ When did it start? _____
Due to an injury? Y N (Explain) _____ Illness? _____
Did the symptoms begin: Suddenly or Gradually Previous Problems in this area? Y/N
Is the problem getting: Better Same Worse Is the problem better with rest? Y/N
Does activity make you worse? Y/N Which activities? _____
Is your pain: Continual Occasional What reduces your pain? _____
Does your pain radiate? Y N Where? _____
What can’t you do because of your symptoms? _____
Recent Tests: X-RAY CT MRI EMG Other _____
Based on a 0 to 10 scale (0 is none and 10 is severe), what is your pain:
Right Now: _____ Highest in past 24 hours: _____ Lowest in past 24 hours: _____

Physical Therapist Signature **Date**