O'NEILL PHYSICAL THERAPY SERVICES

INTAKE FORM

(Please Print)

PATIENT NAME:______________________________ M / F /Other Date of Birth _____/_____/______

E-mail Address: ____

Phone Numbers: Please mark preferred Hm: ________________Cell: _____________ Wk: ______________

Address: ___________________________________ City:___________________State: _____ Zip:_________

Can we discuss your medical information with someone? Name:______________________________________

Leave a detailed message on your answering machine? Yes No

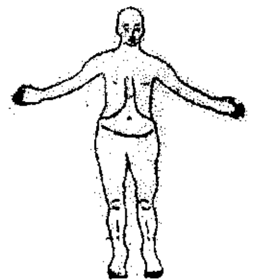
Emergency Contact: ____Phone: ________________________

Referring Physician:____

Family Physician: ____

Reason you were referred:_______________________________

On diagram please indicate your major area of pain or disability:



Do you have or have you had in the past: (Please circle or check)

Pregnant now/due date: _______
History of back or neck problems
Jaw pain
Arthritis
Rheumatoid Arthritis
Fibromyalgia
Osteoporosis
Steroid use for more than two months
Migraines/Headaches
Dizziness, vertigo, balance problems
Seizures
Surgeries/dates:

Parkinsons
Multiple Sclerosis
CVA/Stroke/TIA
Cardiac Problems
High Blood Pressure
Lung Disorders
Allergies/Asthma
Diabetes
Peripheral neuropathy
Recent weight loss/gain
Urinary or fecal incontinence

Cancer: Kind/when

:

Other

____

____

Medications, vitamins and supplements:____

____

____

Signature: ____ Date: ____________________