Carlson Therapy Network, PC

MEDICAL HISTORY INTAKE

Name_____Maiden Name/AKA_____
Referring MD and Office Location_____
Emergency Contact Name and Phone_____ (_____)_____-_____
Are you currently working? F/Time P/Time Has this changed since your illness/injury?_____
What kind of activities do you enjoy?_____
How has this changed since your illness/injury? _____
Date of Injury or Onset _____ Date of Surgery_____
If this was an injury, how did it occur? _____
Have you had any physical therapy as of January 1st? _____ If yes, how many visits?_____
Have you had any diagnostic testing for this condition? Yes No
If so, what type? (X-ray, MRI etc)_____
Have you received any rehabilitative services for this condition? Yes No
If so, what type? (PT, chiropractic, etc.)_____
Are you currently taking any medications?
If so, please list: Anti-Inflammatory _____
Pain Medication _____
Other (state purpose)_____
_____
Please rate your pain on a scale of 1-10 (0 for no pain, 10 for worst pain)_____
Do you have any pins or metal implants? Yes No Do you have a pacemaker? Yes No
Do you smoke? Yes No If yes, how much?_____ Are you pregnant? Yes No
Do you drink alcohol? Yes No If yes, how much?_____

Are you scheduled for any upcoming surgical procedures? (describe) _____

Please check and specify any condition(s) you have or have had in the past:

☐ Emotional/Psychological Problems	☐ Hernia	☐ High blood pressure
☐ Coronary Heart Disease/Angina	☐ Blood Clot/Emboli	☐ Dizziness or faintness
☐ Severe or frequent headaches	☐ Heart Attack/Surgery	☐ Vision difficulties
☐ Asthma/Bronchitis	☐ Emphysema	☐ Sleeping difficulties
☐ Shortness of breath	☐ Weight Loss/Gain	☐ Hearing difficulties
☐ Stroke/TIA	☐ Varicose veins	☐ Epilepsy/Seizures
☐ Thyroid/Goiter	☐ Anemia	☐ Energy Loss
☐ Motor Vehicle Accident_____	☐ Diabetes	☐ Gout
☐ Frequent UTI's	☐ Lyme Disease	☐ Latex/Adhesive Allergy

If any of the following are checked off, please provide specific information

☐ Numbness or tingling_____	☐ Arthritis/Swollen joints _____
☐ Muscle weakness _____	☐ Cancer _____
☐ Osteoporosis _____	☐ Joint Replacement _____
☐ Shoulder injury/surgery_____	☐ Elbow injury/surgery _____
☐ Neck injury/surgery_____	☐ Knee injury/surgery _____
☐ Back injury/surgery_____	☐ Leg/Ankle/Foot injury/surgery_____
☐ Bowel or Bladder problems_____	☐ Infectious disease_____

☐ Allergies _____
Please describe any conditions that would assist us in your care _____
_____

I authorize you to speak with the following person (people) regarding my condition or appointments:
Name_____ Relationship _____
Name_____ Relationship _____

I hereby agree and give my consent to medical treatment regarding my physical condition. I authorize the release of any medical information needed to process my claim. I understand I am responsible for any charges that are not covered by my insurance carrier. Furthermore, I understand I am responsible to inform the office of any changes that occur.

Patient/Parent/Guardian Signature_____ Date:_____
Please initial to acknowledge you have received and read the "Notice of Privacy Practices" _____

_____ Patient submitted ID _____ Patient did not submit ID