Tell Us Your Story…

The information you provide here is extremely important. Thorough past and present health information ensures that your treatment is safe and appropriate for you. Thank you for taking the time to record these details.

Full legal name: _____ Height: _____

Date your symptoms started: _____ Weight: _____

Health and Well Being

☐Y ☐N Do you have a pacemaker?

☐Y ☐N Do you have a latex allergy?

☐Y ☐N Do you smoke/use tobacco?

☐Y ☐N Are you or could you be pregnant?
Due date: _____

☐Y ☐N Do you have an inserted/implanted device in your body (e.g., an IUD, insulin pump, etc.)?

☐Y ☐N Are you allergic to any medications? (*please list)*
_____
_____

☐Y ☐N Have you ever taken **steroid** medications?

☐Y ☐N Have you ever taken **blood thinners** or **anticoagulant** medications?

☐Y ☐N Have you fallen in the past year?
How many times without injury? _____
How many times with injury? _____

☐Y ☐N Do you ever feel unsafe at home or has anyone tried to injure you in any way?

☐Y ☐N Do you like your job?

☐Y ☐N During the past month have you felt down, depressed or hopeless?

☐Y ☐N During the past month have you experienced little interest or pleasure in doing things?

Is this something with which you would like help? ☐Yes ☐Yes, but not today ☐No

Medication List (*list **or attach** all your current prescribed and/or over-the-counter medications including pills, injections, hormones, supplements, etc.) *a separate sheet can be provided if needed*

Medication Name	Dosage	Frequency	Route
Example: ibuprofen	*250 mg*	*Twice daily*	*Oral*

Past Medical History

(check all that apply now or in the past)

☐AIDS
☐Aneurysm *(you/your family)*
☐Anxiety
☐Arthritis
☐Asthma
☐Blood clots
☐Cancer
☐Chest pain
☐Cough/wheeze
☐Depression
☐Diabetes
☐Emphysema
☐Epilepsy
☐GERD/reflux
☐Gout
☐Heart attack
☐Hepatitis
☐High blood pressure
☐High cholesterol
☐Leg or arm swelling
☐Liver problems
☐Lung problems
☐Neurologic disorder
☐Osteopenia
☐Osteoporosis
☐Pneumonia
☐Sleep apnea
☐Stroke
☐Thyroid disease
☐Tuberculosis
☐Ulcer/vascular disease
☐Vision problems
☐Other:_____

Have you experienced any of the following in the last 4 weeks? (Check all that apply)

☐Bladder changes
☐Bowel changes
☐Change in memory or thinking
☐Chest pain
☐Difficulty breathing
☐Dizziness/ lightheadedness
☐Fatigue
☐Fever/chills/sweats
☐Heartburn/indigestion
☐Incontinence of urine or feces
☐Nausea/vomiting
☐Night pain
☐Numbness/tingling
☐Shortness of breath
☐Weakness
☐Weight loss/gain
☐Other: _____

Surgical History

Have you had surgery related to the condition we are treating today? ☐Y ☐N Date of Surgery: _____

Type of surgery: _____

Prior surgeries: _____
(list and date) _____
_____
_____

Client Self-Assessment

Name: _____

Your Meaningful Goals

What are three important things that you are having difficulties doing as a result of your symptoms?

(e.g., walking, lifting, driving, going up/down stairs, etc.)

	Rate ← unable to perform at all ---------- same level as before injury →										
	0	1	2	3	4	5	6	7	8	9	10
1. _____	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
2. _____	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
3. _____	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

What kind of work/hobbies do you do? _____

What movements and positions do your work/hobbies require you to perform? _____

How You Feel Now

What pain or concern are you coming in for today?

_____

☐ Work related ☐ Flare of old injury ☐ Sports injury
☐ Auto accident ☐ Other: _____

Describe what happened: _____

_____

_____

Have you had these symptoms before? ☐ Y ☐ N
When: _____

Have you been off work due to injury? ☐ Y ☐ N
Off work due to injury since: _____

Have you had any tests for these symptoms? (check all that apply)
☐ X-ray ☐ CAT/CT scan ☐ MRI ☐ Bone Scan
☐ Blood test ☐ Electrical test ☐ Other: _____

Have you had other treatments for this condition?
(e.g., chiro, injection, acupuncture, PT, etc.)

Treatment	**Result:** increase/decrease/same

My symptoms are: ☐ decreasing ☐ increasing ☐ staying the same

My symptoms *increase* with: ☐ sitting ☐ standing ☐ lying down ☐ walking

My symptoms *decrease* with: ☐ sitting ☐ standing ☐ lying down ☐ walking

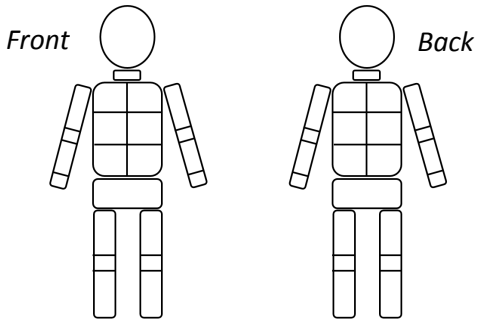
My best time of day is: ☐ morning ☐ afternoon ☐ evening ☐ overnight

Symptom Scale

	no symptoms	1	2	3	4	5	6	7	8	9	10
Right at this moment	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
At its **BEST** in the last 2 days	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
At its **MOST** in the last 2 days	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Use the diagrams to indicate areas of your symptoms

P……pain
T……tingling
N……numbness
B……burning
C……cramping
S……shooting



I certify that this information is accurate and complete to the best of my knowledge. I understand that providing thorough medical information is essential for my physical therapist and medical provider to understand my health, condition, and design a safe and appropriate treatment for me. My treatment implies no promise or guarantee of cure or improvement in my condition, and to be effective, I must attend therapy as prescribed and comply with my home exercise program. ***For minors only:*** *As a parent/legal guardian, I authorize treatment of the minor named above while I am not present.*

X: _____

Signature (parent or guardian if minor) Relationship, if not signed by client Date

For internal use only
Complete at check-in ___
Entered in EMR ___

Client Intake

Full legal name:	Address:
Preferred name:	Apt/suite #:
Date of birth:	City:
Social security:	State:
Sex (check one): ☐ Male ☐ Female ☐ Other: _____	Zip code:
Preferred pronouns: (check all that apply) ☐ She/Her ☐ They/Them ☐ He/Him ☐ Other: _____	Cell phone:
	Home phone:
Emergency contact:	Email:
Relationship:	Appointment reminders: (check one) ☐ call cell ☐ text cell ☐ call home ☐ none
Phone:	

☐ **I request appointment reminders**. I understand I am responsible for attending appointments as scheduled and complying with CorePhysio's missed appointment policy, regardless of whether courtesy reminders are delivered.

☐ **I give permission for my clinical team at CorePhysio to communicate with me by email**, including links to my home exercise plan, financial/billing, insurance, and general information about my condition.

☐ **I give permission for CorePhysio to leave detailed messages on my voicemail/answering machine**.

Referral Information

Primary care provider:	Referring provider:
What most influenced your decision to come to CorePhysio? ☐ personal network ☐ website ☐ medical provider ☐ other	

Health Insurance

Primary insurance:	Secondary insurance:
ID #: Group #:	ID #: Group #:
Subscriber:	Subscriber:
Subscriber birthdate:	Subscriber birthdate:
Employer:	Employer:

Auto Accident and Work Place Injuries - only complete if applicable.*

**CorePhysio does not accept third party MVA claims*

☐ Workplace injury, employer name: ☐ Auto accident that occurred in: (State/Prov)

Injury/accident date: Claim #: If MVA, available PIP? ☐ Y ☐ N

Payer: Claim Manager: Phone:

Release of Information / Annual Notice of Privacy Practices and Financial Policies

☐ **I give permission for CorePhysio to disclose my healthcare or billing** information with the following people (e.g., family, friends, legal counsel, caregivers). It is not necessary to list other healthcare providers. (Optional)

Name(s)	*Relationship*	*Information to be disclosed*
		☐ All health information OR ☐ Treatment ☐ Scheduling ☐ Financial ☐ Diagnosis
		☐ All health information OR ☐ Treatment ☐ Scheduling ☐ Financial ☐ Diagnosis

☐ **I have been offered copies of the Notice of Privacy Practices (HIPAA disclosure) and CorePhysio's Financial Policies & Practices.** I understand the documents can be viewed and downloaded at corephysiopt.com.

☐ **I authorize my insurance benefits to be paid directly to CorePhysio.** I am financially responsible for any balance due, including services not covered by my by insurance plan. I authorize the release of all information necessary to secure payment of benefits and the use of this signature on all insurance submissions. A scan/photocopy of this document is considered as valid as the original. Appointments missed or canceled with less than 48 hours' notice are subject to a $30 fee that is my responsibility.

X: _____

Signature (parent or guardian if minor) Relationship, if not signed by client Date