# Patient Intake Paperwork

Date _____ Legal Name _____
(First) (Middle) (Last)

Preferred Pronoun: He/ Him ○ She/Her ○ They/Them ○ Only My Name ○ No Preference ○ Pronoun not listed: _____

Chosen Name or Nickname _____ Date of Birth _____

Sex listed on Insurance Male ☐ Female ☐

Address: _____
(Street) (City) (State) (Zip Code)

Preferred method of communication: Cell Phone ☐ Home Phone ☐ Day Phone ☐ Email ☐

Preferred Phone # _____ **To receive messages related to appointment reminders, insurance and billing information via telephone, SMS text messaging, and/or email, please check here*** ☐

*By checking the box above, I authorize Total Body Rehab to send me information about my appointments, appointment reminders, and insurance, account or billing items via email, SMS text message, or my preferred phone, or any other phone number that I provide to Total Body Rehab. I also authorize Total Body Rehab personnel to leave a voice mail with information related to my appointments, appointment reminders, insurance, account or billing items. I also represent that I understand that there is some level of privacy risk associated with each of these forms of communication.

## Consent to Email Communication

I agree to receive email communication regarding appointment updates and marketing communication from Total Body Rehab at the following email address: _____

Employer Name _____ Employer phone _____

Employer Local Address _____

HR Department Contact _____ HR Dept. phone _____

**How did you hear of Total Body Rehab? (Please choose one below)**

Advertisement ☐ Internet ☐ Total Body Rehab Website ☐ School ☐ Club Sport ☐ Performing Arts ☐ Insurance ☐ Professional Sports Team ☐ Race ☐ Endurance Training Group ☐ Total Body Rehab Location/Signage ☐ Physician Referral ☐ Other ☐ Please specify name/organization: _____

## Consent to Verbal Communication

I give permission to the following person(s) to receive detailed verbal information regarding my appointments, medical care, billing and payment information. I understand this **DOES NOT** authorize the disclosure of my written health information.

Name _____ Relationship _____

Name _____ Relationship _____

## Emergency Contact Information

Person to contact in case of an emergency:

_____ _____ _____
Name Telephone Number Relationship

## Physician Information

Referring Physician _____ Phone _____

Address _____

Next physician appointment: **Date** _____ **Time** _____

Do you have a Primary Care Physician? Yes ☐ No ☐

If yes, would like us to send copies of correspondence to your primary care physician? Please complete:

Primary Care Physician _____ Phone _____

Address _____

TOTAL BODY REHAB

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**Insurance**

Have you verified your therapy benefits with your insurance? Yes ☐ No ☐

Have you had Physical/Occupational therapy this calendar year? Yes ☐ No ☐

How many treatments (include Chiropractic) have you received this calendar year? _____Former Patient? Yes ☐ No ☐

**Health Insurance**

Primary Insurance Company _____ID#_____Group #_____

Policyholder name _____Relationship _____DOB _____

Secondary Insurance Company _____ID# _____Group # _____

Policyholder name _____Relationship _____DOB _____

**Auto Accident / Personal Injury**

Is this an Auto Accident? Yes ☐ No ☐ Is this a Personal Injury? Yes ☐ No ☐

Date of Accident _____

In what City and State did this occur? _____ Is this a lawsuit? Yes ☐ No ☐

Attorney/Firm Name _____Attorney Phone _____

**Work Comp**

Is this an approved Workers Comp Injury? Yes ☐ No ☐ Date of Injury_____

In what City and State did the injury occur? _____Job Title _____

Attorney/Firm Name _____ Attorney Phone _____

**Please make sure Employer information is filled out on previous page.*

**Medical History**

Age _____ Height _____ Weight _____

What problem(s) are you being treated for today? Describe type and location of symptoms _____

_____

What date (roughly) did your present symptoms start? _____

My symptoms are currently: Getting Better ☐ Getting Worse ☐ Staying the Same ☐

My symptoms currently: Come and go ☐ Are Constant ☐ Constant, but change with activity ☐

What makes your symptoms better? _____

What makes your symptoms worse? _____

What time of the day are your symptoms worse?: Morning ☐ Afternoon ☐ Evening ☐ Overnight ☐

Have you recently noted any of the following? (Check all that apply)

- ☐ Changes in bowel or bladder function
- ☐ Shortness of breath
- ☐ Nausea/vomiting
- ☐ Weakness/fatigue
- ☐ Headaches
- ☐ Difficulty maintaining balance while walking
- ☐ Difficulty swallowing
- ☐ Weight loss/gain
- ☐ Numbness/tingling
- ☐ Fever/chills/sweats
- ☐ Pain at night
- ☐ Dizziness
- ☐ Lightheadedness
- ☐ Changes in appetite

Treatment received so far for this problem: Chiropractic ☐ Acupuncture ☐ Injections ☐

Physical/Occupational therapy Other _____

Special Tests done: X-Ray ☐ Bone Scan ☐ CT Scan ☐ MRI ☐

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List past Medical History (i.e. falls, surgeries, pacemaker) including dates (indicate if for current condition) _____

_____

_____

List any allergies (i.e. latex, adhesives) _____

List any medications you are allergic to and your reaction _____

Are you pregnant? If yes, how many weeks? _____Have you experienced pregnancy related pain? _____

Have you utilized tobacco in the last 12 months? (Check one) Yes ☐ No ☐

**ONLY** for patients 12-20 years old. If you answered no above, have you ever utilized tobacco? Yes ☐ No ☐

Do you drink alcohol? Yes ☐ No ☐ # of drinks per week: _____

**Fall History**

- Number of falls within the last year? 0 ☐ 1 ☐ 2+ ☐
- Did a fall result in injury? Yes ☐ No ☐

**Pelvic Health Question**

If you are experiencing any of the problems listed below, please check the box and your therapist can discuss potential treatment options with you. Do you have a history of pelvic disorders (i.e. urge/stress incontinence, pelvic floor heaviness, pelvic/bladder or abdominal pain, irregular bowel movements)? Yes ☐

**Social History/Leisure Activities/Exercise Routine**

Home ☐ House ☐ Condo/Apartment ☐ Group Residence ☐ Nursing Home ☐

Do you live alone: Yes ☐ No ☐

Are you currently working: Full Duty ☐ Light Duty ☐ Not working ☐ If not working, date last worked _____

Total Body Rehab complies with applicable Federal civil rights laws and does not discriminate on the basis of race, age, religion, sex, national origin, socioeconomic status, sexual orientation, gender identity or expression, disability, veteran status, or source of payment. You will be treated with dignity, compassion, and respect as an individual.

10/24/22