HEALTH IN MOTION

Intake Form

I. Personal Information

Name: _____ Billing Address: _____

City, State, Zip _____

Home Phone: (_____) _____ Cell Phone: (_____) _____ May we leave a message? Yes No

How did you first hear about Health In Motion? _____

SSN: __ __ __ - __ __ - __ __ __ __ DOB: _____/_____/_____ Age: _____

Work Phone: (_____) _____ E-mail: _____ Marital Status: S/M/D/W

Occupation: _____ Employer: _____ Phone: (_____) _____

Emergency Contact: _____ Phone: (_____) _____

Who is you Primary Care Provider? (MD,DO,PA,NP): _____

Tobacco Use: Yes No Alcohol Use: Yes No

Primary Insured: _____ DOB: _____/_____/_____ Employer: _____

II. Current Symptoms

Problem(s) you are here for: _____

What date (roughly) did your symptoms start? _____

What do you think started your symptoms? _____

Are your symptoms related to a work injury? Yes No or a motor vehicle accident? Yes No

Symptoms are currently: ❑ Getting better ❑ Getting worse ❑ Staying about the same

❑ Come and go ❑ Are constant ❑ Are constant, but change with activity

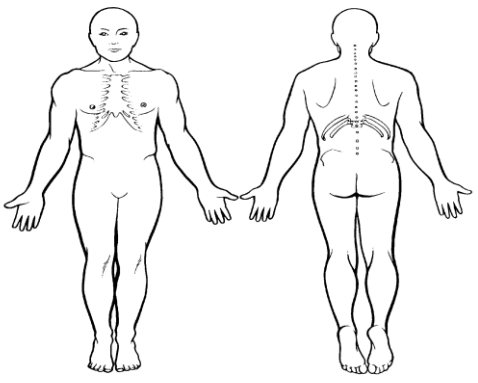
Treatments so far for this problem (injections, chiropractic, etc.): _____

Have you had an x-ray, MRI, or other imaging for this problem? Yes No
If yes, please list: _____

Have you ever had this before? Yes No If yes, when and how was it treated: _____

Body Chart:

- Please mark **all** areas where you feel symptoms on the chart to the right



What makes your symptoms **better**? _____

_____

What makes your symptoms **worse**? _____

_____

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Are your current symptoms disrupting your normal sleep pattern? Yes No

On the scale below, please mark the number which best represents the severity of your pain over the past 24 hours:

0 1 2 3 4 5 6 7 8 9 10

No pain — Worst pain imaginable

SINCE YOUR SYMPTOMS BEGAN, have you noted any of the following (check all that apply)?

- ❑ Fatigue
- ❑ Generalized muscle weakness
- ❑ Dizziness/lightheadedness
- ❑ Weight loss/gain
- ❑ Difficulty maintaining balance while walking
- ❑ Changes in bowel or bladder function
- ❑ Numbness or tingling
- ❑ Falls
- ❑ Shortness of breath
- ❑ Heartburn/indigestion
- ❑ Difficulty swallowing
- ❑ Headaches
- ❑ Fever/chills/sweats
- ❑ Nausea/vomiting
- ❑ Abdominal pain
- ❑ Fainting
- ❑ Cough
- ❑ Other _____

III. Medical History

Have you EVER been diagnosed with any of the following conditions (check all that apply)?

- ❑ Cancer Year: _____
- ❑ Heart problems
- ❑ Chest pain/angina
- ❑ High blood pressure
- ❑ Circulation problems
- ❑ Blood clots
- ❑ Stroke
- ❑ Anemia
- ❑ Chemical dependency (i.e. alcoholism)
- ❑ Depression
- ❑ Lung problems
- ❑ Tuberculosis
- ❑ Sexually transmitted disease/HIV
- ❑ Rheumatoid arthritis
- ❑ Osteoarthritis
- ❑ Bladder/urinary tract infection
- ❑ Kidney problem/infection
- ❑ Cholesterol - high/low
- ❑ Thyroid problems
- ❑ Diabetes
- ❑ Osteoporosis
- ❑ Multiple sclerosis
- ❑ Epilepsy
- ❑ Hepatitis
- ❑ Ulcers
- ❑ Liver problems
- ❑ Other

Past surgical history (list & date): _____

Please list current medications: _____

During the past month have you been feeling down, depressed, or hopeless? Yes No
During the past month have you been bothered by having little interest or pleasure in doing things? Yes No
Is this something with which you would like help? Yes Yes, but not today No

Do you ever feel unsafe at home or has anyone tried to hit you or injure you in any way? Yes No
If you are over 65, how many falls have you had in the last 6 months? _____

IV. Authorization

I authorize my insurer to pay any benefits for physical therapy services to HIM. I understand that anything not covered by my insurance is fully my responsibility. I hereby authorize HIM through its appropriate personnel to perform or have performed on me, or the patient named below, appropriate assessment and treatment procedures relating to my diagnosis. I further authorize HIM to release to appropriate agencies any information acquired in the course of my examination/treatment and permit a photographic or other facsimile or this authorization to be used in place of the original assignment. I have reviewed and understand the notice of privacy practices. A copy of this authorization will be provided upon request.

Patient's (parent/guardian if minor) Signature: _____ Date: _____

Guardian Relationship: _____