HEALTHCARE PHYSICAL THERAPY

13638 Sibley Rd., Riverview, MI 48193
Ph: 734.288.3739 • Fx: 734.288.3745

Personal Intake Form

Name ______________________ Date of First Visit __________

Gender Male ○ Female ○ Date of Birth __________ Height ______ Weight ______

Date of Onset/ Surgery Date __________ Is this complaint related to: Auto ○ Work ○ Sports ○

Briefly explain how you were injured or how complaints began.

Do you have implants in your body? Yes○ No ○

Have you had any surgical procedures? Yes○ No ○

Do you smoke? Yes○ No ○

Do you consume alcoholic beverages? Yes○ No ○

Currently or recently received home care services? Yes○ No○

Any allergies *(bee sting, latex, medication, etc.)*? Yes○ No○

If female, is there a possibility you are pregnant? Yes○ No○

Have you recently been hospitalized? Yes○ No ○

If yes, please provide date and reason below.

Date ______ Reason ______________________

Date ______ Reason ______________________

Date ______ Reason ______________________

Date ______ Reason ______________________

Please list any previous treatments for your current condition.

Did any of the above treatments help? Yes ○ No ○

Please list any diagnostic testing for your current condition *(x-ray, MRI, CT, EMG, etc.)*

Please list any medications that you are currently taking.

Please check if you have a history of any of the following:

Lung disease ☐	Blood clot ☐	Heart Disease ☐	Seizures ☐	Bleeding Disorder ☐
Asthma ☐	Bowel/bladder ☐	Diabetes ☐	Arthritis ☐	Osteoporosis ☐
Psychiatric ☐	High Blood Pressure ☐	Cancer ☐	Hepatitis ☐	Thyroid ☐

*this information will remain confidential within your chart. Please complete it as thoroughly as possible. Your Therapist will address any further questions or concerns.

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Do we have permission to leave a message on your answering machine/ voice mail, with a family member or a legal representative regarding appointments, billing or other matters regarding your treatment?

Yes ◯ No ◯

Other ◯ if other, please specify ______________________________

May we call you at work?

Yes ◯ No ◯ Work # ______________

ACKNOWLEDGEMENT

I acknowledge that I have received the **Notice of Privacy Practices.**

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Patient Name ***(please print)***

______________________________ ______________
Patient or Personal Representative Signature Date

If Personal Representative's signature appears above, please describe Personal Representative's relationship to patient.