Patient Intake Form

2000 W Wickenburg Way #200, Wickenburg AZ
Phone: 928-668-0108; Fax 928-668-0110

First Name: _____ Middle Init: _____ Last Name: _____

Preferred Name (if different): _____ Social Security No.: _____

Birthdate: _____ Gender: ◯ M ◯ F Marital Status: ◯ Single ◯ Married ◯ Widowed

Email (used for appointment reminders): _____

If Patient is a Minor, Parent(s) or Guardian's name: _____

Primary Phone No.: _____ Type: ◯ Cell ◯ Home ◯ Work

Secondary Phone No.: _____ Type: ◯ Cell ◯ Home ◯ Work

Mailing Address: _____

City: _____ State: _____ Zip: _____

Physical Address, if different: _____

City: _____ State: _____ Zip: _____

Guarantor (if patient is a minor)

Guarantor's Name: _____

Guarantor's Address, if different: _____

City: _____ State: _____ Zip: _____

Referring Physician

Physician Name: _____ Phone No.: _____

Emergency Contact Information

Name of Emergency Contact: _____

Relationship to Patient: _____ Phone No.: _____

Insurance Information (Please give your insurance cards and photo id to the receptionist.)

Is your treatment today regarding either a work-related accident or an auto-accident injury? ◯ Yes ◯ No

Primary Insurance _____ Group No.: _____

Subscriber's Name, if other than patient: _____ Policy No.: _____

Patient's Relationship to Subscriber: ◯ Self ◯ Spouse ◯ Child ◯ _____ Subscriber's Birthdate: _____

Secondary Insurance _____ Group No.: _____

Subscriber's Name, if other than patient: _____ Policy No.: _____

Patient's Relationship to Subscriber: ◯ Self ◯ Spouse ◯ Child ◯ _____ Subscriber's Birthdate: _____

I hereby certify the above information is true and correct to the best of my knowledge. I understand that while Champion Physical Therapy contracts with many insurance companies, it is my responsibility to verify with my plan that Champion Physical Therapy is a participating provider. It is also my responsibility to find out what my coverage options are with my insurance plan. I further understand that Champion Physical Therapy will assist me in obtaining authorization from my primary care physician or insurance company if necessary. If however, authorization is not obtained, I may be financially responsible for services rendered. I hereby authorize Champion Physical Therapy to submit insurance claim forms along with medical records necessary to obtain payment from my insurance company. I understand that I am responsible for all charges regardless of insurance coverage. I acknowledge that photo IDs taken are used to assist in patient recognition per HIPAA guidelines.

Signature: _____ Date: _____

Patient Medical History

Patient Name: _____

Mark the column labeled "YES" for those conditions you are **CURRENTLY** experiencing:

YES		YES	
◯	Asthma, Bronchitis, or Emphysema	◯	Osteoporosis
◯	Shortness of Breath / Chest Pain	◯	Sleeping Difficulties
◯	High Blood Pressure	◯	Bowel or Bladder Problems
◯	Epilepsy / Seizures	◯	Weight Loss / Gain
◯	Anemia	◯	Any Pins or Metal Implants
◯	Diabetes / Type _____	◯	Emotional / Psychological
◯	Arthritis / Where? _____	◯	Pregnant
		◯	Smoking

◯ None of the Above

Mark the column labeled "YES" for those conditions you have **EVER** had:

YES		Date	YES		Date
◯	Coronary Heart Disease or Angina		◯	Hernia	
◯	Pacemaker / Defibrillator	_____	◯	Joint Replacement Surgery	_____
◯	Heart Attack / Heart Surgery	_____	◯	Ankle / Foot Injury / Surgery	_____
◯	Stroke / TIA	_____	◯	Neck Injury / Surgery	_____
◯	Blood Clot / Emboli	_____	◯	Back Injury / Surgery	_____
◯	Infectious Disease	_____	◯	Shoulder Injury / Surgery	_____
◯	Cancer / Type _____	_____	◯	Knee Injury / Surgery	_____
◯	Gout		◯	Elbow / Hand Injury / Surgery	_____
◯	Vision or Hearing Difficulties		◯	Other_____	

◯ None of the Above

Medications

Please list any medications you are taking (or provide us with a photocopy), with the dose and frequency.

Medication Name	Dose (i.e. 10 mg)	Frequency (i.e. one a day)

Please list Vitamins, Supplements, and Over-the-Counter Medicines

_____

_____

Patient/Parent Signature: _____ Date: _____

Injury Assessment Form

1. Patient Name: _____ Injury: _____

2. Date of Injury/Onset of Episode?_____ Have you had surgery for this injury? ◯ Yes ◯ No

3. Type of Surgery: _____ Number of Surgeries: ____ Date of Surgery: _____

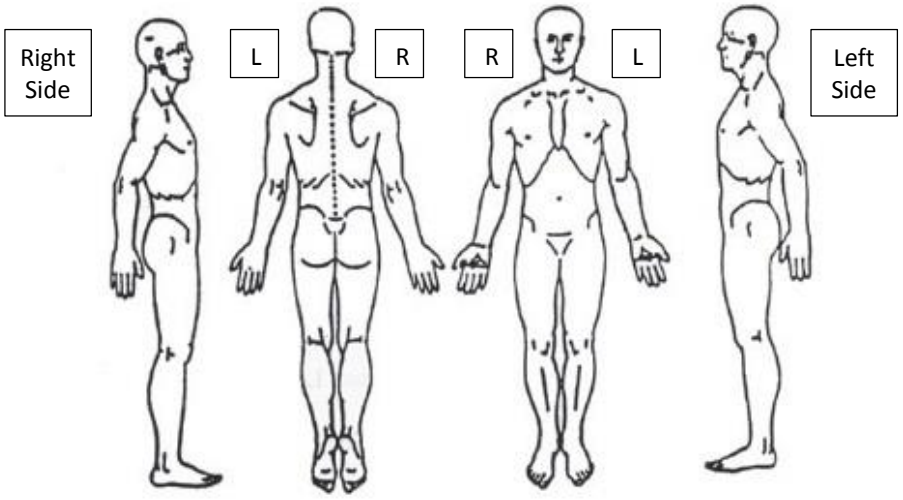
4. Have you received any of the following medical or rehabilitative services to treat this injury or episode?

Services	Yes	No	Helpful	Not Helpful
Physical Therapy	☐	☐	☐	☐
Chiropractic	☐	☐	☐	☐
Podiatric	☐	☐	☐	☐
Neurologic	☐	☐	☐	☐
Orthopedic	☐	☐	☐	☐
Home Health	☐	☐	☐	☐

Service	Yes	No	Helpful	Not Helpful
Injections	☐	☐	☐	☐
Narcotic	☐	☐	☐	☐
MRI	☐	☐		
X-Ray	☐	☐		
CT Scan	☐	☐		
EMG/NCV	☐	☐		

5. How often does the pain occur? ◯ Constant ◯ Several Times a Day ◯ Several Times a Week

6. Please mark the area on the picture where you feel pain or other symptoms.



7. Rate Your Pain Below: 0 = No Pain 10 = Take Me to E.R.

At its WORST in the past three days:	0	1	2	3	4	5	6	7	8	9	10
Right Now:	0	1	2	3	4	5	6	7	8	9	10
At its BEST in the past three days	0	1	2	3	4	5	6	7	8	9	10

8. How do you describe the pain? _____

9. What aggravates your pain? _____

10. What relieves your pain? _____

11. Do you have numbness, weakness, or tingling? ◯ No ◯ Yes, where: _____

12. Do you experience dizziness or fainting? ◯ No ◯ Yes, when: _____

13. What are your goals/expectations from physical therapy?_____