DORSET PHYSIO 909 Route 30, Dorset, VT 05251 Phone 802-867-7056 Fax 802-440-0280

PATIENT INTAKE FORM

Name________________________________ **D.O.B**. ____________________ **DATE:** ______________

DATE OF ONSET OF SYMPTOMS: __________ **DATE OF SURGERY OR INJURY (if applicable):** ___________

MAILING ADDRESS (required): ____

PHYSICAL ADDRESS (IF DIFFERENT FROM MAILING): ____

PHONE (*one required*) (*CELL)* ______________________ **(HOME)** _________________ **(WORK)**_________________

EMAIL ADDRESS: (*required*) _____________________________________

PREFERRED CONTACT METHOD (CIRCLE ALL OR ONE): EMAIL, VOICE, OR TEXT

EMERGENCY CONTACT: ________________________ ***(PHONE)*** _______________ ***(RELATIONSHIP)*** ____________

REFERRING PROVIDER OR NO REFERRAL? __________________________________

REFERRING DOCTOR NAME (FIRST, LAST): ____

REFERRING DOCTOR PHONE:_____________________________ ***(CITY, STATE)*** __________________________

PRIMARY CARE PHYSICIAN NAME (FIRST, LAST):____

PRIMARY CARE PHONE:_____________________________ ***(CITY, STATE)*** __________________________

HOW DID YOU HEAR ABOUT US? IF A FRIEND, PLEASE TELL US WHO SO WE MAY THANK THEM ________________

PRIMARY INSURANCE INFORMATION:
INSURANCE CARRIER: _____________________________ INSURANCE PHONE NUMBER: _________________
SUBSCRIBER NAME: ____________________________ SUBSCRIBER DOB: ____________________
SUBSCRIBER ID#: ______________________________. GROUP #:___________________________
RELATION TO SUBSCRIBER: ____________________________

SECONDARY INSURANCE INFORMATION (REQUIRED FOR MEDICARE PATIENTS*)
INSURANCE CARRIER: _____________________________ INSURANCE PHONE NUMBER: _________________
SUBSCRIBER NAME: ____________________________ SUBSCRIBER DOB: ____________________
SUBSCRIBER ID#: ______________________________. GROUP #:___________________________
RELATION TO SUBSCRIBER: ____________________________

******MEDICARE PATIENTS REQUIRE A PART B PLAN FOR OUTPATIENT PHYSICAL THERAPY HERE AT DORSET PHYSIO. IF YOU ARE A MEDICARE PATIENT AND DO NOT HAVE A SECONDARY PLAN, PLEASE SPEAK WITH OUR PATIENT COORDINATOR PRIOR TO YOUR APPOINTMENT.*

WORKERS COMP OR AUTO PATIENTS ONLY:
SS # ___ ___ ___ / ___ ___ / __ __ __ (SS# required for WC claims) DATE OF INJURY:______________________
LIGHT DUTY OR FULL DUTY: ____________________ OUT OF WORK SINCE: _________________________
EMPLOYER: ____________________________ EMPLOYER ADDRESS: _______________________________
WC INSURANCE COMPANY: __________________________________ ADDRESS ____________________________
TELEPHONE # _________________ CASE MANAGER NAME ____________________ CLAIM # ______________________

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PATIENT HEALTH HISTORY FORM

Name______________________________________ **Date of Birth:** ________________ **Date:**______________

Gender: ____________ **Preferred Pronoun: She/her/hers He/him/his They/them/theirs**

Date of Onset of Symptoms: ___________ **Date of Surgery or Injury (if applicable):** ____________

Current Complaint/Concern (why you are here for physical therapy):

____

Have you seen any other health professional(s) for this condition? YES NO If yes, who? _____________

Have you had any of the following for your condition? ▢**MRI** ▢ **X-Ray** ▢**CT Scan**

Have you ever been to PT? ***(circle)*** **YES NO If so, how many times this year?** ________________
Are you currently receiving any HOME HEALTH CARE? YES NO End Date: _______________________
Injury work related? ***(circle)*** **YES NO Employer**___________________________
Injury motor vehicle related? ***(circle)*** **YES NO If yes, are you currently working with an Attorney? YES NO**

Please list all Medications, Vitamins/Supplements: *(please bring your medication list or write on the back if needed):*

____

Do you use any drugs or alcohol? Y N What and how frequent?____________________________________

Do you smoke or vape? Y N If year, what type and how many years? _______________________________

Are you allergic to LATEX? Y N Any other Allergies? ____

Do you now have, or have you had, any of the following?

Heart Disease/Attack	YES NO	Diabetes	YES NO
Cancer ____________	YES NO	Seizures	YES NO
Pregnant (currently)	YES NO	High Blood Pressure	YES NO
Dizziness	YES NO	Osteoporosis	YES NO
Stroke	YES NO	Asthma/COPD	YES NO
Chronic Headaches	YES NO	Arthritis/Joint Pain	YES NO
Tooth/Jaw/Ear Pain	YES NO	Previous Physical Therapy	YES NO
Past Surgeries	YES NO	Anxiety/Depression	YES NO

Any other History or Information that would assist in your visit today:

____

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PAIN DIAGRAM

Please draw on the bodies below the right the locations of your pain, and indicate the nature of your pain (best, worst, time of day, and if it is intermittent or constant). ***0=NO PAIN 10=EXCRUCIATING PAIN***

CURRENT: 0 1 2 3 4 5 6 7 8 9 10

BEST: 0 1 2 3 4 5 6 7 8 9 10

WORST: 0 1 2 3 4 5 6 7 8 9 10

IS YOUR PAIN (circle one):

INTERMITTENT OR CONSTANT

TIME OF DAY PAIN IS BEST (circle one):

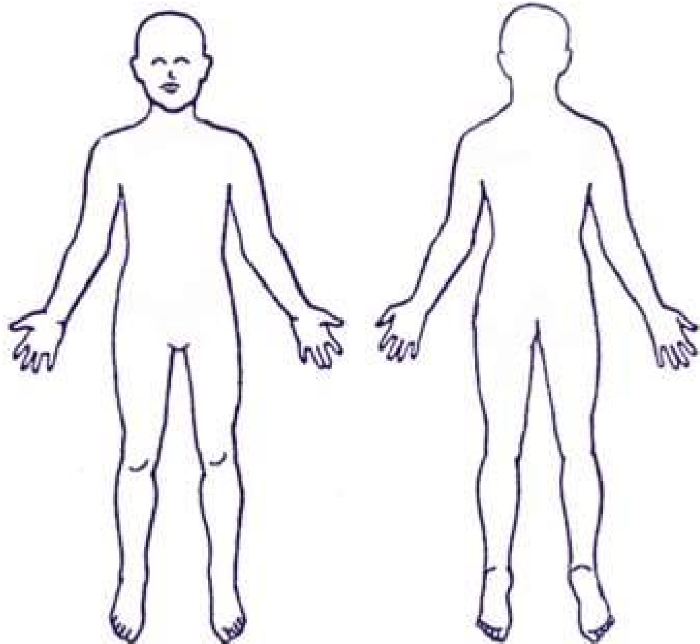
MORNING AFTERNOON NIGHT

WHICH IS BEST: SITTING, STANDING OR WALKING? ___________________

TIME OF DAY PAIN IS WORSE (circle one):

MORNING AFTERNOON NIGHT

WHICH IS WORSE: SITTING, STANDING OR WALKING? ___________________



If you are 65 and over OR have sustained a fall please answer these questions:
Have you had any falls in the past 6 months?*(circle one)* **YES NO How many:_____________**
Any fall(s) that resulted in injury?*(circle one)* **YES NO**
If answered YES to any fall or injury from a fall, please describe here:

____

Do you use any Assistive Devices/Equipment (circle all that apply): Cane Walker Crutches Walking Poles Wheelchair Brace/Splint Lift Chair Shower Chair Bedside Commode

Please List at least 2 goals you have for Physical Therapy:

1. ____
2. ____

The information above is accurate to the best of my knowledge.

Patient Signature: ______________________________ **Date:** ________________________

Printed Name: _________________________________