Expert Physical Therapy

21600 Novi Rd, Suite 400, Novi, MI 48375
18899 W. 12 Mile Rd, Lathrup Village, MI 48076
30180 Orchard Lake Rd, Farmington Hills, MI 48334

Patient Intake Form

Personal Information

Full Name:_____ D.O.B.:_____/_____/_____

(M) Phone:_____ Email:_____

Home Address:_____

Referring Provider:_____

Date of Referral:_____/_____/_____ Clinic Location:_____

Primary Care Doctor:_____

How did you hear about us?:_____

Injury Description

Injury Location: _____

Physician Diagnosis:_____

Approximate Date of Injury:_____

Injury Cause :_____

Have you received treatment for this before? **(Circle one)**: YES / NO

If yes, what treatment was done?:_____

Pain Type **(circle all that apply)**: DULL / ACHY / TENDERNESS / TINGLING / SHARP / SHOOTING / BURNING / STABBING / RADIATING / THROBBING / OTHER

If other, please describe it:_____

Circle your current level of pain **(10 being the worst)**: 1 2 3 4 5 6 7 8 9 10

Circle pain level at its WORST **(10 being the worst)**: 1 2 3 4 5 6 7 8 9 10

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When is your pain at its BEST? **(time of day and activity level)**:

_____

When is your pain at its WORST? **(time of day and activity level)**:

_____

General Medical History

Height: _____ Weight:_____ Average Blood Pressure:_____

Have you fallen recently?: YES / NO If yes, when did you last fall?:____/____/____

Do you feel unsteady? YES / NO Are you worried about falling? YES / NO

Please list any of the following OR provide a current list:

Past surgeries along with the date:

_____

_____

_____

_____

Current medical conditions:

_____

_____

_____

_____

Current medication list with dosage:

_____

_____

_____

_____

Patient Signature:_____ Date:_____/_____/_____