PAIN CENTER OF MORRIS
Physical Therapy Department
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Patient Personal Information

Welcome Please take a few minutes to complete our intake forms. This information will help us to best serve you and will be kept confidential. Please let us know if you have any questions. Let's get started!

Today's Date: _____ Patient Name: _____ Social Security #: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone #: _____ Work Phone#: _____ Cell Phone: _____
What's the best number to reach you on? _____ E-mail Address: _____
Sex: □ Male □ Female Age: ___ Date of birth: _____ □ Married □ Single □ Separated □ Divorced □ Widowed
Spouse's Name: _____ Children? □Yes □ No If yes, how many and what age/s? _____
Occupation: _____ Employer/School Name: _____
Employer: _____
In case of emergency, contact:
Name: _____ Relationship to you: _____ Phone #: _____
Primary care physician name: _____ Phone #: _____
If you are seeing any specialists (ie neurologist, orthopedist etc), please tell us who and their specialty:
_____

How did you find out about us? Please check all that apply:

□ Friend/Family Member If so, Who? _____
□ Physician Physician's name: _____
□ Walk-in/Drive-by
□ Internet Website: _____
□ Phone Book
□ You're a returning patient
□ Other _____

Were you injured in an auto or work related accident? □Yes □No
□ Auto □ Work Accident date: _____
Do you have an attorney? □ Yes □ No
If so, attorney's Phone number: _____
Claim #: _____
What is the name of the person handling your case at the insurance company? _____
What is their Phone #? _____

How will you be paying for treatment?
□ Health Insurance □ Auto Insurance
□ Worker's Comp Insurance □ Self-pay (cash/ Check/credit)

Insurance Information

Primary insurance company name: _____
Policy holder's name: _____
Policy holder's date of birth: _____
Relationship to patient: _____
ID/Policy #: _____
Group #: _____

Secondary insurance? □ Yes □ No Name: _____
Policy holder's name: _____
Policy holder's date of birth: _____
Relationship to patient: _____
ID/Policy #: _____
Group #: _____

Patient Signature: _____ **Date: _____**

Signature of parent if minor: _____ **Date: _____**
Patient Name: _____ Date: _____

Now it's time to address the reason/s of your visit today. Please answer the following and be as complete as possible. We look forward to being of service!

Are you here for a specific complaint/s or for general health & wellness?

_____

Take a look at the diagram of the human body to the right & mark any place/s where you are experiencing pain.

What symptom/s are you experiencing?

_____

_____

When did this start hurting?

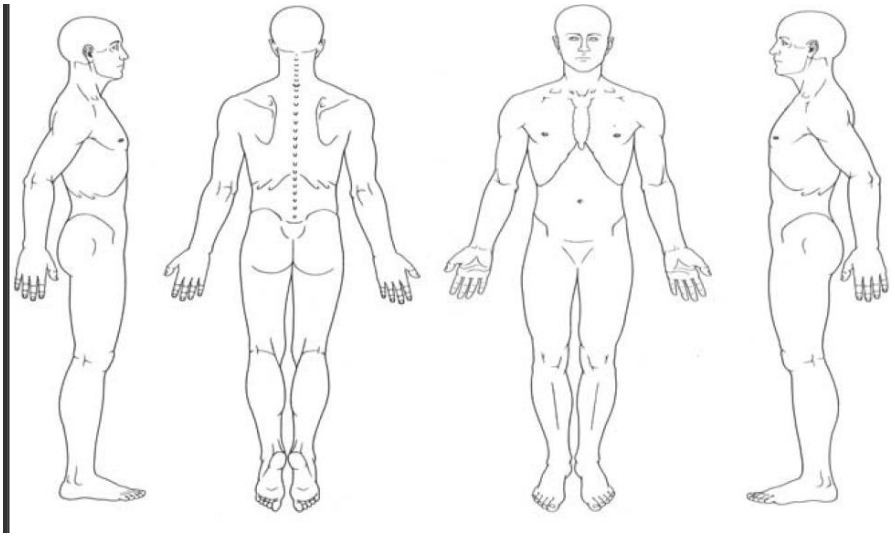
_____

Do you know what caused this (i.e. accident, gradual, woke up that way, etc)?

_____

How would you describe your pain?

□ Sharp □ Burning □ Dull
□ Tingling □ Cramps □ Numbness
□ Stiffness □ Aching □ Swelling
□ Shooting □ Throbbing
□ Other _____



Mark an "X" on the line indicating your pain **RIGHT NOW:**

_____

None Most Severe

Mark an "X" on the line indicating your pain **AT IT WORST:**

_____

None Most Severe

Is this pain constant? □ Yes □ No If no, how often does it bother you? _____
What movements, positions, treatment, or other factors make you feel better? _____

_____

What movement, positions, treatment, or other factors make you feel worse? _____

_____

Does this seem to be getting worse? □ Yes □ No Have you ever had this or something similar in the past? □ Yes □ No
If yes, please explain: _____
Is this radiating to other parts of your body> □ Yes □ No If yes, to where? _____
Is this interfering with your sleep, work, daily routine, etc? □ Yes □ No If yes, please explain: _____

_____

Have you had any x-rays or MRIs done of the area that is bothering you? □ Yes □ No

If yes, _____ □ X-ray _____ _____
What region of your body was done? □ MRI What facility did you go to? Date of test
_____ □ X-ray _____ _____
What region of your body was done? □ MRI What facility did you go to? Date of test

Is there anything else you would like us to know? □ Yes □ No
If yes, please share: _____

_____

_____

_____

Patient Name: _____ Date: _____

Past Medical History Check any that you currently have OR have had in the past:

□ AIDS/HIV	□ Diabetes	□ Liver disease	□ Rheumatic fever
□ Alcoholism	□ Eating disorder	□ Migraine Headaches	□ Scarlet fever
□ Allergy shots	□ Emphysema	□ Miscarriage	□ Sexually transmitted disease
□ Anemia	□ Epilepsy/seizures	□ Mononucleosis	□ Stroke
□ Appendicitis	□ Glaucoma	□ Multiple sclerosis	□ Thyroid problem
□ Arthritis	□ Goiter	□ Mumps	□ Tonsillitis
□ Artificial limb/joints	□ Gout	□ Osteoporosis	□ Tuberculosis
□ Asthma	□ Heath disease	□ Pacemaker	□ Tumors, growths
□ Bleeding disorder	□ Hepatitis	□ Parkinson's disease	□ Typhoid fever
□ Brain injury	□ Hernia	□ Pinched nerve	□ Ulcers
□ Breast lump	□ Herniated disc	□ Pneumonia	□ Vaginal infections
□ Bronchitis	□ High blood pressure	□ Polio	□ Whopping cough
□ Cancer	□ High cholesterol	□ Prostate problem	□ Other _____
□ Cataracts	□ Kidney disease	□ Psychiatric care	
□ Chicken pox	□ Light headed/dizzy	□ Rheumatoid arthritis	

Please describe any injuries or surgeries you've had **and when:**
Falls _____
Head injuries _____
Broken bones _____
Dislocations _____
Surgeries _____

Lifestyle Habits
Do you exercise? □ Yes □ No If yes, what type and how often? _____
Describe your work activity: □ Sitting □ Standing □ Light labor □ Heavy labor

Do you…
Smoke? □ Yes □ No Packs per day ____ Drink alcohol? □ Yes □ No Drinks per week ____
Drink coffee/Caffeine? □ Yes □ No Cups per day _____ Take street drugs? □ Yes □ No Times per week ____
Take any medications? □ Yes □ No If yes, what do you take? _____
_____
Have any allergies? □ Yes □ No If yes, what are you allergic to? _____
_____
Take vitamins/herbs/minerals? □Yes □ No If yes, What do you take? _____
_____
Are you pregnant? □ Yes □ No If yes, due date? _____