PERSONAL INTAKE FORM

Name: _____ Gender: M / F
Date of Birth: _____
Address: _____
Phone Number: _____

Date of Onset of Problem: _____ Auto/Sports/Work/ Surgery related?_____
Do you participate in any sports/recreation activities?_____

Do you have any implants in your body? Y / N
If post surgical, have you received home care services? Y / N
Have you recently been hospitalized for your condition? Y / N
Please provide orthopedic surgeries and dates below:

Date	Orthopedic Surgeries

Please list any previous treatments for your current condition:
_____
_____

Did any of the above treatments help? Y / N
Please list any diagnostic testing done for your current condition:
_____

Do you have any allergies? (skin sensitivity, medication, latex, etc):
_____

Please list or provide a copy of any medications you are currently taking:_____
_____

If you are female, is there a possibility that you are pregnant? Y / N

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

__ Stomach Disorders	__ High Blood Pressure	__ Arthritis
__ Asthma	__ Heart Disease	__ Hepatitis
__ Psychiatric	__ Diabetes	__ Bleeding Disorder
__ Blood Clot	__ Cancer	__ Seizures
__Bowel/Bladder	__ Osteoporosis	__ Thyroid