PT Intake Form

ALTIUS
PERFORMANCE

Name:_____**Today's Date:**_____
Age:_____**DOB:**_____**Sex: M**___**F**____**Other**_____**Height:**_____**Weight:**_____
Occupation:_____
Street Address:_____
City:_____**State:**_____**Zip:**_____
Home Phone:_____**Cell Phone:**_____
Email:_____
Emergency Contact:_____
Occupation:_____**Sport(s):**_____
Injury:_____**Referring Physician:** _____

What is your primary complaint?

_____
_____
_____

When and how did your problem begin?

_____
_____
_____

Have you had this problem before? (Circle) Yes No
If "yes", when and how did you get better?_____
_____
_____

Have you had diagnostic imaging done (X Ray, MRI, CT Scan, etc)? Yes No
If "yes", please explain: _____
_____
_____

Using the pain scale below, mark current pain level:

No Pain Worst Pain Imaginable

Describe your pain (Circle all that apply):

Dull	Aching	Sharp	Stabbing
Pins & Needles	Shooting Pain	Burning	Throbbing
Twinge	Numbness/Tingling	Other:	Other:
Constant	Intermittent	Fluctuates with Activity	Other:

Does your pain wake you up at night? Yes No

What makes it worse? (Circle all that apply)?

Sitting	Standing	Walking	Running
Lifting	Bending	Squatting	Twisting
Changing Positions	Sit<>Stand	Kneeling	Other:
Sport Movement:	Sport Movement:	Sport Movement:	Sport Movement:

What makes it better?

Sitting	Standing	Walking	Running
Lifting	Bending	Squatting	Twisting
Changing Positions	Sit<>Stand	Kneeling	Rest
Heat/Ice (Circle)	Medication:_____	Other:	Other:

Is your problem affecting your ability to participate in work or sports? Yes No

If yes, please explain limitations:_____

_____

_____

Do you have any other orthopedic problems? Yes No

If yes, please explain: _____

_____

_____

Any previous surgeries? Yes No

If yes, please explain:_____

_____

_____

_____

Do you have a history of any of the following medical conditions?(Circle all that apply)

Cancer/Tumors	Osteoporosis	Depression/Anxiety	Dizziness/Blackouts
Heart Problems/Angina	Diabetes	Pacemaker	Sudden Weight Loss/Gain
Smoking	Bruising Easily	Asthma	Loss of Bowel/Bladder Control
Seizures/Epilepsy	High Blood Pressure	Numbness/Tingling	Loss of Coordination
Other (Explain)			

Please list ALL medications (prescription AND over the counter) and reason for taking:

_____

_____

_____

Please list all nutritional supplements you are currently taking:

_____

_____

_____

What are your physical therapy goals?

1._____

2._____

3._____

Thanks for taking the time to fill out this form as completely as possible! It will save us on treatment time during your first visit and will help in assessing your condition and guiding your treatment plan.

Release of Liability

I have read, understood and answered these questions to the best of my knowledge, and I will alert Altius Performance (Altius) should any changes occur in the information provided. I have been informed of and I understand that any exercise program, even under the supervision of a medical professional, is a potentially hazardous activity. Through my voluntary participation I assume all associated risks. I hereby waive, release and discharge Altius and its representatives for any and all claims or liabilities for injuries or damages to my person or possession. I agree to indemnify and hold Altius and its representatives harmless from all losses, liabilities, damages, costs or expenses (including but not limited to reasonable attorneys' fees and other litigation costs and expenses) incurred as a result of any claims or suits threatened or brought by me or on my behalf against Altius or its representatives to recover any losses, liabilities, costs, damages, or expenses.

Patient Signature: _____Date:_____

Parent/Guardian Signature (if under 18 years):_____Date:_____

By signing below, I consent patient to be photographed, filmed and/or otherwise recorded, and I agree that Altius Performance may use images of me and my name for any purpose whatsoever in perpetuity and without compensation.

Patient Signature:_____Date:_____

Parent/Guardian Signature (if under 18 years):_____ Date:_____