ATHLETICO PHYSICAL THERAPY

Patient Intake Paperwork

Date _____ Legal Name _____ Date of Birth_____
(First) (Last) (Middle)

Address: _____
(Street) (City) (State) (Zip Code)

Preferred Name or Nickname_____

Gender Listed on Insurance _____ Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Widow/Widower

Cell Phone _____ **To receive appointment reminder text messages, please check here** ☐

Preferred method of communication (choose one): ☐ Email ☐ Home Phone ☐ Day Phone ☐ Cell Phone

What is your primary language? _____ Do you need an interpreter? ☐ Yes ☐ No

You have the right to an interpreter at no cost. If you need these services, notify your Clinician or Office Coordinator.

Employer Name _____ Employer phone _____

Employer Local Address _____

HR Department Contact _____ HR Dept. phone _____

How did you hear of Athletico? (Please choose one below)

☐ Advertisement ☐ Internet ☐ Athletico Website ☐ School ☐ Club Sport ☐ Performing Arts ☐ Insurance
☐ Professional Sports Team ☐ Race ☐ Endurance Training Group ☐ Athletico Location/Signage ☐ Physician

Other: Please specify name/organization: _____

Consent to Email Communication

I agree to receive email communication regarding appointment updates and marketing communication from Athletico Physical Therapy at the following address: _____

Consent to Verbal Communication

I give permission to the following person(s) to receive detailed verbal information regarding my appointments, medical care, billing and payment information. I understand this **DOES NOT** authorize the disclosure of my written health information.

Name _____ Relationship _____

Name _____ Relationship _____

I understand Athletico personnel may call my home phone number or other alternative number and leave a voice mail or in person in reference to appointment reminders, insurance or billing items. I also authorize the release of appointment information left in a voice-mail, answering machine or text message and understand that there is some level of privacy risk associated with these forms of communication.

Emergency Contact Information

Person to contact in case of an emergency:

_____ _____ _____
Name Telephone Number Relationship

Physician Information

Referring Physician _____ Phone _____

Address _____

Next physician appointment: **Date** _____ **Time**_____

Do you have a Primary Care Physician? ☐ Yes ☐ No

If yes, would like us to send copies of correspondence to your primary care physician? Please complete:

Primary Care Physician _____ Phone _____

Address _____

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Insurance

Have you verified your therapy benefits with your insurance? (choose one) ☐ Yes ☐ No

Have you had Physical/Occupational therapy this calendar year? ☐ Yes ☐ No

How many treatments (include Chiropractic) have you received this calendar year? _____ Former Patient? ☐ Yes ☐ No

Health Insurance

Primary Insurance Company_____ID#_____Group #_____

Policyholder name_____Relationship_____DOB_____

Secondary Insurance Company_____ID#_____Group #_____

Policyholder name_____Relationship_____DOB_____

Auto Accident

Is this an Auto Accident? ☐ Yes ☐ No Date of Accident _____

In what City and State did this occur? _____ Is this a lawsuit? ☐ Yes ☐ No

Attorney/Firm Name _____ Attorney Phone _____

Work Comp

Is this an approved Workers Comp Injury? ☐ Yes ☐ No Date of Injury _____

In what City and State did the injury occur? _____ Job Title _____

Attorney/Firm Name _____ Attorney Phone _____

**Please make sure Employer information is filled out on previous page.*

Medical History

Age_____ Height_____ Weight_____

What problem(s) are you being treated for today? Describe type and location of symptoms _____

_____

What date (roughly) did your present symptoms start? _____

My symptoms are currently (choose one): ☐ Getting better ☐ Getting worse ☐ Staying the same

My symptoms currently (choose one): ☐ Come and go ☐ Are constant ☐ Constant, but change with activity

What makes your symptoms better? _____

What makes your symptoms worse? _____

What time of the day are your symptoms worse? (choose one): ☐ Morning ☐ Afternoon ☐ Evening ☐ Overnight

Have you recently noted any of the following? (Check all that apply)

- ☐ Changes in bowel or bladder function
- ☐ Shortness of breath
- ☐ Nausea/vomiting
- ☐ Weakness/fatigue
- ☐ Headaches
- ☐ Difficulty maintaining balance while walking
- ☐ Difficulty swallowing
- ☐ Weight loss/gain
- ☐ Numbness/tingling
- ☐ Fever/chills/sweats
- ☐ Pain at night
- ☐ Dizziness
- ☐ Lightheadedness
- ☐ Changes in appetite

Have you ever been diagnosed with dementia? ☐ Yes ☐ No

Treatment received so far for this problem (check all that apply): ☐ Chiropractic ☐ Acupuncture ☐ Injections

Physical/Occupational therapy Other_____

Special Tests done: ☐ X-Ray ☐ Bone Scan ☐ CT Scan ☐ MRI

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List past Medical History (i.e. falls, surgeries, pacemaker) including dates (indicate if for current condition)

_____

_____

List any allergies (i.e. latex, adhesives) _____

Medications *Please provide names of all medications, vitamins, supplements, and over-the-counter drugs you are currently taking. We can copy a detailed list if you have one.*

Medication Name	How much (dose)	How often	How taken (circle one)
_____	_____	_____	☐ointment ☐pill ☐drop ☐patch ☐injection ☐inhaler
_____	_____	_____	☐ointment ☐pill ☐drop ☐patch ☐injection ☐inhaler
_____	_____	_____	☐ointment ☐pill ☐drop ☐patch ☐injection ☐inhaler
_____	_____	_____	☐ointment ☐pill ☐drop ☐patch ☐injection ☐inhaler
_____	_____	_____	☐ointment ☐pill ☐drop ☐patch ☐injection ☐inhaler

List any medications you are allergic to and your reaction_____

Are you pregnant? If yes, how many weeks? _____ Have you experienced pregnancy related pain? _____

Have you utilized tobacco in the last 24 months? (Choose one) ☐ Yes ☐ No

ONLY for patients 12-20 years old. If you answered no above, have you ever utilized tobacco? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No # of drinks per week: _____

Over the past 2 weeks, how often have you been bothered by any of the following problems?

- Little interest or pleasure in doing things: ☐ Not at all ☐ Several Days ☐ More than one half of days ☐ Nearly every day
- Feeling down, depressed, or hopeless: ☐ Not at all ☐ Several Days ☐ More than one half of days ☐ Nearly every day

Fall History

- Number of falls within the last year? ☐ 0 ☐ 1 ☐ 2+
- Did a fall result in injury? ☐ Yes ☐ No

Are you suffering from abuse (ex: physical, emotional, psychological), neglect, abandonment, material exploitation, or unwarranted control? ☐ Yes ☐ No

Pelvic Health Question

If you are experiencing any of the problems listed below, please check the box and your therapist can discuss potential treatment options with you. Do you have a history of pelvic disorders (i.e. urge/stress incontinence, pelvic floor heaviness, pelvic/bladder or abdominal pain, irregular bowel movements)? ☐ Yes

Social History/Leisure Activities/Exercise Routine

Home: ☐ House ☐ Condo/Apartment ☐ Group Residence ☐ Nursing Home

Do you live alone: ☐ Yes ☐ No

Are you currently working: ☐ Full Duty ☐ Light Duty ☐ Not working If not working, date last worked_____?

What is your current activity level? (choose one below)

☐ Sedentary ☐ Lightly active ☐ Moderately active ☐ Very active ☐ Extremely active

How many days per week do you perform a regular fitness routine? _____

If you have any questions, please contact the Athletico Corporate office:
625 Enterprise Drive, Oak Brook, IL 60523 | tel: 630.575.6200 | 1-877-ATHLETICO | email: info@athletico.com