The Physical Therapy & Wellness Institute
"Bodies Under Repair"™

Recently Returning Patient Update Patient Intake

First Name:_____ Last Name:_____ DOB: _____

Name of Referring Physician: _____ **Next Doctor's Appt:** _____

Family Physician: _____ **Phone Number:** _____

Auto Related: Yes/No **Work Related**: Yes/No **Accident Related**: Yes/No

Body Part: _____ **Right or Left** **Date of Injury**: _____ **Mechanism Of Injury**: _____

Rate Your Pain: **(no pain)0 _____ 5 _____ 10(worst)** **Current Pain Level:** ____/10 **Pain At Worst** ____/ 10 **Pain At Best:** ____/10

Have you had diagnostic tests performed for this injury: Y/N **MRI**: Y/N **X-Ray**: Y/N **Where were they performed**:

Medications: (please indicate dose, frequency)

Drug:

__Fentanyl __ Duragesic __ Hydrocodone __ Vicodin __ Morhone __ Dilaudid __Tylenol/codient

_____/_____ _____/_____ _____/_____ _____/_____ _____/_____ _____/_____ _____/_____

Other Medications (indicate dose/frequency and reason)

_____ _____ _____

_____ _____ _____

_____ _____ _____

Medical History	**Yes**	**No**		**Yes**	**No**
Allergies	☐	☐	Gallbladder Problems	☐	☐
Anemia	☐	☐	Hepatitis	☐	☐
Anxiety	☐	☐	High Blood Pressure	☐	☐
Arthritis	☐	☐	Incontinence	☐	☐
Asthma	☐	☐	Kidney Problems	☐	☐
Cancer	☐	☐	Metal Implants	☐	☐
Cardiac Conditions	☐	☐	Multiple Sclerosis	☐	☐
Cardiac Pacemaker	☐	☐	Osteoporosis	☐	☐
Chemical Dependency	☐	☐	Parkinson's	☐	☐
Circulation Problems	☐	☐	Rheumatoid Arthritis	☐	☐
Currently Pregnant	☐	☐	Seizures	☐	☐
Depression	☐	☐	Speech Problems	☐	☐
Diabetes	☐	☐	Strokes	☐	☐
Dizzy Spells	☐	☐	Thyroid Disease	☐	☐
Emphysema/Bronchitis	☐	☐	Tuberculosis	☐	☐
Fractures	☐	☐	Vision Problems	☐	☐

MEDICARE ONLY

Are you currently receiving home health care services? Yes/No **Name of Agency**:_____ Phone:_____

If Yes, what type of home health care services: _____ **Last date of service**: _____

Have you received PT, OT or Speech therapy services since the first of the year? Yes/No **Height**:_____ **Weight**:_____

Have you fallen in the past 6 months? Y or N / Have you fallen in the past 12 months? Y or N

Would you like us to perform a fall risk safety assessment of your home? Y or N

To be completed by PTW Staff:

_____ I have confirmed the patient's address and contact information has not changed since their last discharge from PTW.

_____ The contact information has changed: **Email**: ____ **Home Phone:**____ **Mobile Phone:**____ **Other phone:**____ **Address**:____

Please list updated info here: _____

_____ **I have updated WebPT**. **Staff initials:** _____

I have read and understood Physical Therapy & Wellness Institute's privacy notice. I further that I may obtain a copy of this privacy notice upon request

Patient Signature: _____ **Date**_____ **(Rev 5-16-17)**