JEAN ANNE ZOLLARS, PT, DPT, MA

PATIENT INTAKE INFORMATION

CLIENT INFORMATION

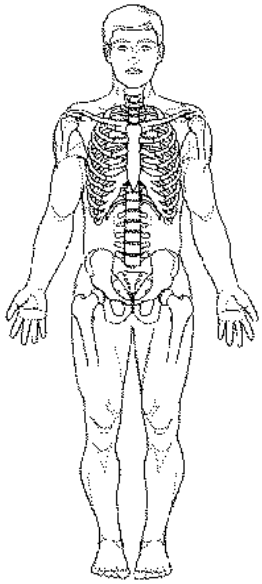
Client Name:_____ Date:_____
Address: _____ Home Phone:_____
City, State, Zip_____ Office Phone:_____
Cell Phone:_____

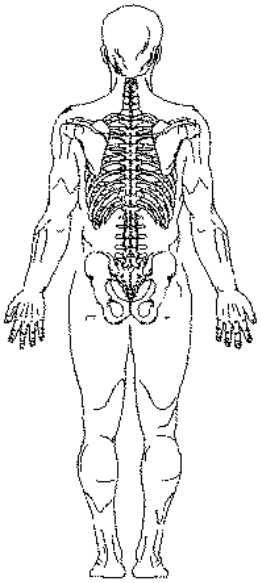
Age:_____ Date of Birth:_____
Occupation: _____
Employer:_____ Address: _____
Weight _____ Sex: M ( ) F ( ) Referred by:_____
Doctor's Name_____ Phone # _____
Married ( ) Single ( ) Widowed ( ) Divorced ( ) Partnered ( ) Children _____
Contact in case of emergency: Name_____ Phone _____
Name of parent if client is a minor _____
Have you ever had chiropractic, physical therapy, massage therapy or alternative health care before? For what problem?_____
_____

SYMPTOMS & COMPLAINTS

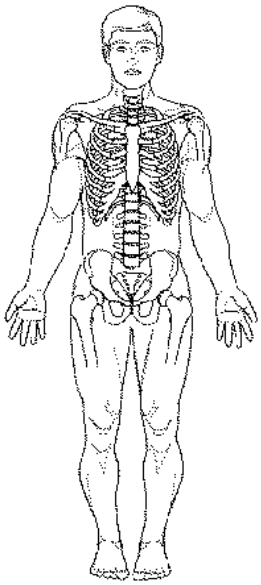
Please list your major complaints and symptoms – be as specific as you can: _____
_____
_____
How do you believe your problem (pain) began? _____
_____
Have you lost any work because of this problem?_____ Date you last worked _____
What is your official diagnosis? _____

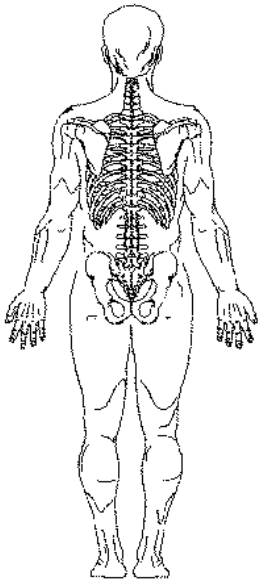
PAIN DIAGRAM: Please shade in all areas of pain. Indicate the severity of pain on a scale of: 0 (none) to 10 (excruciating), & type of pain (sharp, aching, dull, knifelike)





PARAESTHESIA DIAGRAM: Please shade in all areas of "funny feelings" (tingling, burning, pins and needles, etc.)





SYMPTOMS	never	occasional	often	constant
Dizziness, Lightheadedness	____	____	____	____
Nausea	____	____	____	____
Ringing, stuffy or painful ears	____	____	____	____
Vision problems	____	____	____	____
Balance or coordination problems	____	____	____	____
Chest pain	____	____	____	____
Decreased concentration	____	____	____	____
Memory problems	____	____	____	____
Bowel problems	____	____	____	____
Bladder problems	____	____	____	____
Unusual bleeding or discharge	____	____	____	____
Difficulty sleeping	____	____	____	____
Night sweats	____	____	____	____
Fever, chills	____	____	____	____

What was the date of onset of your last menses?_____

MEDICAL HISTORY

Please indicate your present medical status: illnesses, diseases, fractures: _____

_____

_____

Indicate your past history of health: illnesses, diseases, fractures:_____

_____

_____

List operations you have undergone and dates: _____

_____

_____

List all trauma and when it occurred (All trauma in the past – accidents, falls, injuries are important) _____

_____

_____

List all medications (including vitamins, herbs or over the counter drugs) you are presently taking_____

_____

List all medications you have taken in the last 5 years _____

_____

List any diagnostic tests (X-ray, MRI, etc.) you have had and the results _____

_____

Circle if you have any of the following: IUD pacemaker stints breast implants

FUNCTION

List your present hobbies _____

Describe any regular exercise or sports you presently do _____

_____

Please indicate your ability to do the following activities:	difficult	painful	unable	not applicable
Lying on back	_____	_____	_____	_____
Lying on stomach	_____	_____	_____	_____
Lying on right side	_____	_____	_____	_____
Lying on left side	_____	_____	_____	_____
Turning over back-stomach	_____	_____	_____	_____

Please indicate your ability to do the following activities:	difficult	painful	unable	not applicable
Turning over stomach-back	_____	_____	_____	_____
Kneeling on knees	_____	_____	_____	_____
Sitting up from lying down	_____	_____	_____	_____
Lying down from sitting up	_____	_____	_____	_____
Sitting on a chair	_____	_____	_____	_____
Sitting in a car	_____	_____	_____	_____
Driving	_____	_____	_____	_____
Standing up from the floor	_____	_____	_____	_____
Standing up from the chair	_____	_____	_____	_____
Standing up straight	_____	_____	_____	_____
Walking	_____	_____	_____	_____
Bending (vacuuming)	_____	_____	_____	_____
Lifting objects from the floor	_____	_____	_____	_____
Lifting objects from the table	_____	_____	_____	_____
Reaching arms above head	_____	_____	_____	_____
Dressing/undressing	_____	_____	_____	_____
Bathroom and hygiene	_____	_____	_____	_____
Other: Sports & leisure activities	_____	_____	_____	_____
Work	_____	_____	_____	_____
_____	_____	_____	_____	_____

Are you involved in any lawsuits related to your pain? Check below if appropriate:

____I have no lawsuit pending

____I am in the process of suing the State or an insurance company to receive compensation benefits for my pain.

____I am in the process of suing an individual who is partly/totally responsible for my pain problems.

CLIENT AGREEMENT AND RELEASE FROM LIABILITY

I, _____ (name) agree to the following during and after the course of my therapy. (Initials)

1) I will not use any mood altering substance (drug and alcohol) before coming to a session. _____

2) At any time during a session, I have the right to stop the therapy if I feel uncomfortable or unsafe. _____

3) I understand that I am responsible for my well being and healing process and that the therapist can not "fix" or cure me. _____

4) I understand that the therapist is committed in assisting me to heal myself in the shortest time possible. _____

5) I understand that there may be reactions to treatment, anticipated or unanticipated, and that it is my responsibility to discuss any symptoms of concern with the therapist. _____

6) If I need to cancel an appointment, I will do so 24 hours prior to the appointment. I understand that a late fee will be charged if I cancel less than 24 hours prior to the appointment. _____