

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: _____

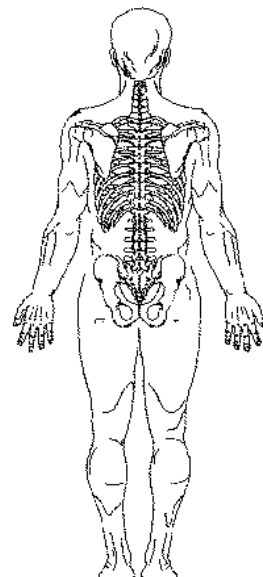
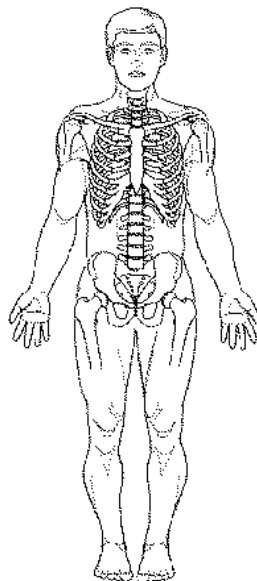
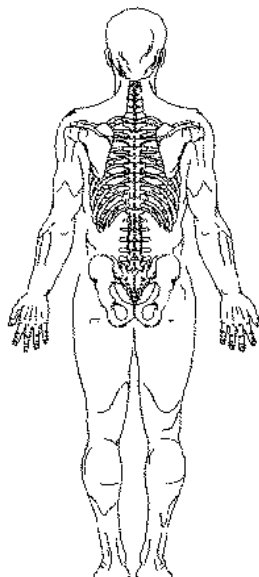
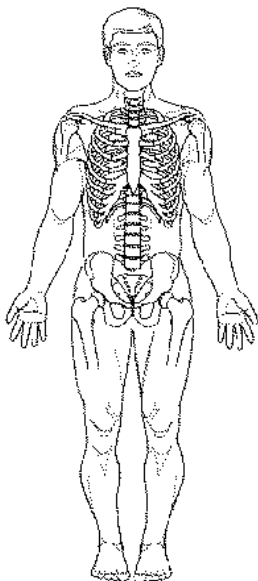
How do you believe your problem (pain) began? _____

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

	<u>never</u>	<u>occasional</u>	<u>often</u>	<u>constant</u>
Dizziness, Lightheadedness	_____	_____	_____	_____
Nausea	_____	_____	_____	_____
Ringings, 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:	<u>difficult</u>	<u>painful</u>	<u>unable</u>	<u>not applicable</u>
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:	<u>difficult</u>	<u>painful</u>	<u>unable</u>	<u>not applicable</u>
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. _____

