Active Recovery
Physical Therapy & Sports Rehab

250 S Lake St, Suite E
East Jordan, MI 49727

Phone: 231.222.2121
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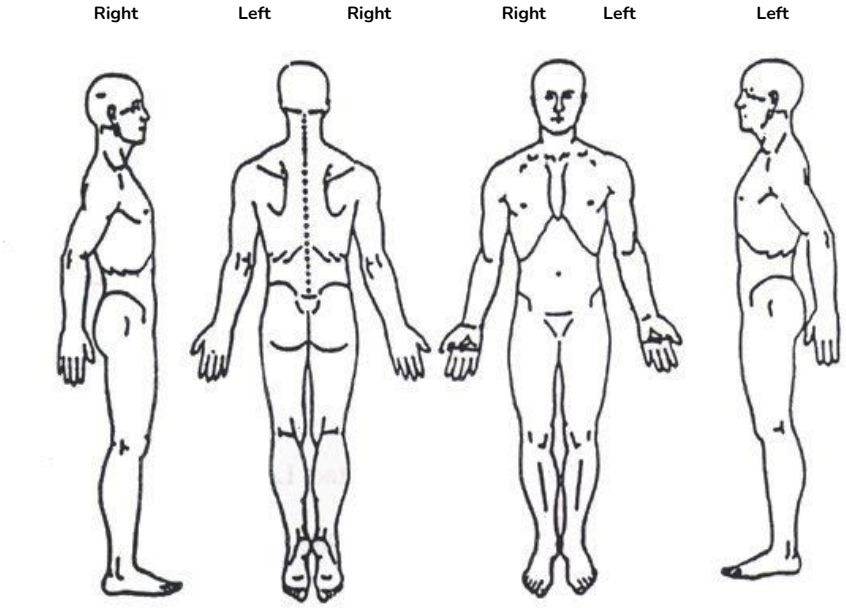
Patient Intake Form

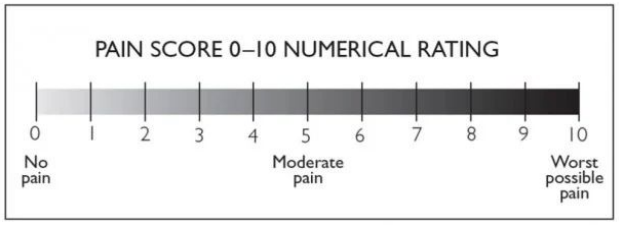
Name:_____ **DOB:** _____ / _____ / _____

For what are you seeking treatment? _____

Date of injury/surgery:_____ **Is condition related to:** ☐ **Work** ☐ **Auto**

How much pain do you have with this condition? Circle the area of pain and/or symptoms and indicate level of pain below:





I would describe my pain as:

☐ **Constant** ☐ **Intermittent**
☐ **Sharp** ☐ **Dull**
☐ **Burning** ☐ **Aching**
☐ **Other:** _____

What, if anything, relieves your symptoms? _____

What, if anything, worsens your symptoms? _____

Have you had this issue before? ☐ **No**
☐ **Yes, how many episodes** _____ **time since previous episode** _____ **avg duration of episode** _____

Past medical/surgical history: please check all that apply

☐ **Diabetes**	☐ **Lymphedema**
☐ **Heart disease**	☐ **Cancer: _____ Remission: Y / N**
☐ **High blood pressure**	☐ **Osteoarthritis / Rheumatoid Arthritis**
☐ **High cholesterol**	☐ **Anxiety / Depression**
☐ **Stroke**	☐ **Past surgeries:**

_____

☐ **Other:**

_____

Please list or provide separate documentation detailing current medications, including those prescribed or over the counter for pain/symptom management:

Please list any known drug or environmental allergies, such as latex:

For Direct Access / Self-Referral Patients, please provide:

Primary Care Physician:_____ Phone Number:_____

Insurance Type: _____ (provide card to clinic for reference)

Have you received any physical, speech, or occupational therapy in this calendar year?

☐ **No** ☐ **Yes, when and where? _____**

As a vital part of the learning process, students may be involved in your care at Active Recovery Physical Therapy & Sports Rehab. You have the right to decline or limit this involvement. Please select the option that you are most comfortable with:

- ☐ **College students may be involved in providing direct treatment.**
- ☐ **College students may work alongside my therapist in providing direct treatment.**
- ☐ **All students (high school or college) may observe only.**
- ☐ **I would prefer no student involvement in my care.**

Consent to Physical Therapy Evaluation and Treatment: I hereby consent to the evaluation and treatment of my condition by a licensed physical therapist or physical therapist assistant employed by Active Recovery Physical Therapy & Sports Rehab. The physical therapist will explain the nature and purposes of these procedures, evaluation, and course of treatment. The physical therapist will inform me of expected benefits and complications, and any discomforts, and risk that may arise, as well as alternatives to the proposed treatment and the risk and consequences of no treatment.

_____	_____	_____
Patient Name	**Signature of Patient or Responsible Party**	**Date**