



Carlson Therapy Network, PC
MEDICAL HISTORY INTAKE

Name \_\_\_\_\_ Maiden Name/AKA \_\_\_\_\_

Referring MD and Office Location \_\_\_\_\_

Emergency Contact Name and Phone \_\_\_\_\_ (\_\_\_\_\_) - \_\_\_\_\_

Are you currently working? F/Time P/Time Has this changed since your illness/injury? \_\_\_\_\_

What kind of activities do you enjoy? \_\_\_\_\_

How has this changed since your illness/injury? \_\_\_\_\_

Date of Injury or Onset \_\_\_\_\_ Date of Surgery \_\_\_\_\_

If this was an injury, how did it occur? \_\_\_\_\_

Have you had any physical therapy as of January 1st? \_\_\_\_\_ If yes, how many visits? \_\_\_\_\_

Have you had any diagnostic testing for this condition? Yes No
If so, what type? (X-ray, MRI etc) \_\_\_\_\_

Have you received any rehabilitative services for this condition? Yes No
If so, what type? (PT, chiropractic, etc.) \_\_\_\_\_

Are you currently taking any medications?
If so, please list: Anti-Inflammatory \_\_\_\_\_
Pain Medication \_\_\_\_\_
Other (state purpose) \_\_\_\_\_

Please rate your pain on a scale of 1-10 (0 for no pain, 10 for worst pain) \_\_\_\_\_

Do you have any pins or metal implants? Yes No Do you have a pacemaker? Yes No

Do you smoke? Yes No If yes, how much? \_\_\_\_\_ Are you pregnant? Yes No

Do you drink alcohol? Yes No If yes, how much? \_\_\_\_\_

Are you scheduled for any upcoming surgical procedures? (describe) \_\_\_\_\_

Please check and specify any condition(s) you have or have had in the past:

- Emotional/Psychological Problems
Coronary Heart Disease/Angina
Severe or frequent headaches
Asthma/Bronchitis
Shortness of breath
Stroke/TIA
Thyroid/Goiter
Motor Vehicle Accident
Frequent UTI's
Hernia
Blood Clot/Emboli
Heart Attack/Surgery
Emphysema
Weight Loss/Gain
Varicose veins
Anemia
Diabetes
Lyme Disease
High blood pressure
Dizziness or faintness
Vision difficulties
Sleeping difficulties
Hearing difficulties
Epilepsy/Seizures
Energy Loss
Gout
Latex/Adhesive Allergy

If any of the following are checked off, please provide specific information

- Numbness or tingling
Muscle weakness
Osteoporosis
Shoulder injury/surgery
Neck injury/surgery
Back injury/surgery
Bowel or Bladder problems
Allergies
Arthritis/Swollen joints
Cancer
Joint Replacement
Elbow injury/surgery
Knee injury/surgery
Leg/Ankle/Foot injury/surgery
Infectious disease

Please describe any conditions that would assist us in your care \_\_\_\_\_

I authorize you to speak with the following person (people) regarding my condition or appointments:

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

I hereby agree and give my consent to medical treatment regarding my physical condition. I authorize the release of any medical information needed to process my claim. I understand I am responsible for any charges that are not covered by my insurance carrier. Furthermore, I understand I am responsible to inform the office of any changes that occur.

Patient/Parent/Guardian Signature \_\_\_\_\_ Date: \_\_\_\_\_

Please initial to acknowledge you have received and read the "Notice of Privacy Practices" \_\_\_\_\_