



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 1<sup>st</sup>? \_\_\_\_\_ 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:**

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

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

Numbness or tingling \_\_\_\_\_  Arthritis/Swollen joints \_\_\_\_\_

Muscle weakness \_\_\_\_\_  Cancer \_\_\_\_\_

Osteoporosis \_\_\_\_\_  Joint Replacement \_\_\_\_\_

Shoulder injury/surgery \_\_\_\_\_  Elbow injury/surgery \_\_\_\_\_

Neck injury/surgery \_\_\_\_\_  Knee injury/surgery \_\_\_\_\_

Back injury/surgery \_\_\_\_\_  Leg/Ankle/Foot \_\_\_\_\_

injury/surgery \_\_\_\_\_  Infectious \_\_\_\_\_

Bowel or Bladder problems \_\_\_\_\_

disease \_\_\_\_\_

Allergies \_\_\_\_\_

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" \_\_\_\_\_

\_\_\_\_\_ Patient submitted ID      \_\_\_\_\_ Patient did not submit ID

10/19/09cdb