Being in Balance Physical Therapy
Client Intake Form

First Name:_____ Last Name:_____ Today's Date:_____
Address:_____ City:_____ State:___ Zip Code:_____
Phone Number:_____ Email Address:_____
Preferred method of communication: ____phone _____text _____email
Date of Birth:_____ Age:_____
Occupation:_____ Employer:_____
Emergency Contact:_____ Phone Number:_____

Responsible Party (if client is a minor):_____
Address:_____ City:_____ State:___ Zip Code:_____
Phone Number:_____ Email Address:_____
Relationship to Client:_____

Primary Care Physician:_____ Phone Number:_____
Address:_____
Primary Insurance:_____ Insured Party's Name:_____

How did you hear about Being in Balance Physical Therapy?_____
May I have permission to contact this person to thank them for referring you?_____

Do you have a written referral from an MD, DO, DC or DPM?_____
Have you received / are you receiving home health physical therapy services?_____
Have you received / are you receiving outpatient physical therapy services?_____
Are you currently receiving any other health / wellness services (such as massage, acupuncture, chiropractic care, energy work)? _____
_____
Do you exercise on a regular basis?_____
Please list your hobbies and recreational activities:_____

Do you have/ have you experienced any of the following? Place an X next to each.

__Allergies
__Anemia
__Aneurysm
__Anxiety
__Asthma
__Autoimmune issues
__Back pain
__Bell's Palsy
__Bladder problems
__Bowel problems
__Blood clots
__Bleeding disorder
__Breastfeeding
__Bursitis
__C-Section
__Car accident
__Cancer
__Candida
__Colitis
__Constipation
__Cosmetic surgery
__Depression
__Diabetes
__Diarrhea
__Dizziness
__Fainting
__Fibromyalgia
__Food sensitivities
__Fungal infections
__Eczema
__Edema
__Epilepsy
__Endometriosis
__Gallbladder issues
__Gastric Reflux
__Headaches
__Heart issues
__Heart Attack
__Heel spur
__Hepatitis
__Herniated disc
__HIV
__High blood pressure
__Incontinence
__Irritable Bowel Syndrome
__Jaw/TMJ issues
__Kidney issues
__Liver issues
__Lung issues
__Lupus
__Lymphedema
__Marijuana use
__MRSA/ Staph infection
__Mastectomy/Lumpectomy
__Menstrual issues
__Migraines
__Miscarriage
__Multiple Sclerosis
__Neurological issues
__Osteoarthritis
__Osteoporosis/Osteopenia
__Pacemaker
__Painful intercourse
__Panic Attacks
__Pelvic Instability
__Plantar Fascitis
__Port/Shunt/Central Line
__Post-partum < 1 year
__Number of births ___
__Psoriasis
__Raynaud's Disease
__Rash or other skin condition
__Recreational drug use
__Rheumatoid Arthritis
__Sciatica
__Seizures
__Shingles
__Smoking
__Spinal Stenosis/Spondylolisthesis
__Sprains
__Stroke/CVA
__Tendonitis
__Thyroid issues
__Tinnitus/ringing in the ears
__Ulcers
__Varicose Veins
__Vertigo
__Vision changes

Other conditions not listed above:_____
_____
_____

Surgeries (with date):_____
_____
_____

Allergies to medications, foods, latex:_____
_____
_____

Current medications and supplements:_____
_____
_____
_____
_____

What is the primary complaint that you are seeking intervention for?_____
_____
_____

Other physical or emotional traumas that you feel comfortable sharing:_____
_____
_____

Please list anything else that you feel would be important for your therapist to know:___
_____
_____

_____ _____
client name date

_____
client signature