Opus
PHYSICAL THERAPY AND PERFORMANCE

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Brief Physical Therapy Intake

Name: ____________________ Date of Birth: ____________________

Street Address: __________ Apt./Unit #: __________ City: __________ State: ______ Zip Code: __________

Mobile Phone #: __________ Home Phone #: __________ E-mail: __________

Preferred Method of Contact
☐ Email ☐ Call (Home) ☐ Call (Cell) ☐ Text (Cell)

Emergency Contact: ____________________ Relationship: __________

Referring Physician (if applicable) ____________________ Primary Care Provider (if applicable) ____________________

Primary Insurance

Primary Insurance Company __________ Member ID / Policy # __________ Group Number __________

Client Relationship to Insured
○ Self ○ Spouse ○ Child ○ Other

Insured Name __________ Insured Phone # __________ Insured Date of Birth __________ Insured Gender
○ Female ○ Male

Insured Street Address __________ Insured City __________ Insured State __________ Zip Code __________

Secondary Insurance

Secondary Insurance Company __________ Member ID / Policy # __________ Group Number __________

Client Relationship to Insured
○ Self ○ Spouse ○ Child ○ Other

Insured Name __________ Insured Phone # __________ Insured Date of Birth __________ Insured Gender
○ Female ○ Male

Insured Street Address | Insured City | Insured State | Zip Code

(Optional) You can upload pictures of your insurance cards (front/back) here:

Are you currently receiving or have you recently received any home health nursing, physical therapy or occupational therapy in the last 30 days?

- ○ Yes
- ○ No

If YES, what was the DISCHARGE date you were last seen by your therapist/nurse?

What is the name of your home health agency? | Telephone #:

Reason for today's visit:

Is the reason for your visit a result of an injury or trauma?

- ○ Yes
- ○ No

Date of Onset/Injury:

Is your injury:

- ○ Auto Related
- ○ Work Related
- ○ Accident Related
- ○ N/A

Have you had surgery for this condition?

- ○ Yes
- ○ No

If yes, date of surgery:

If yes, please describe surgery:

Have you received any other treatment for this condition?

- Yes
- No

In the last week, are your symptoms:

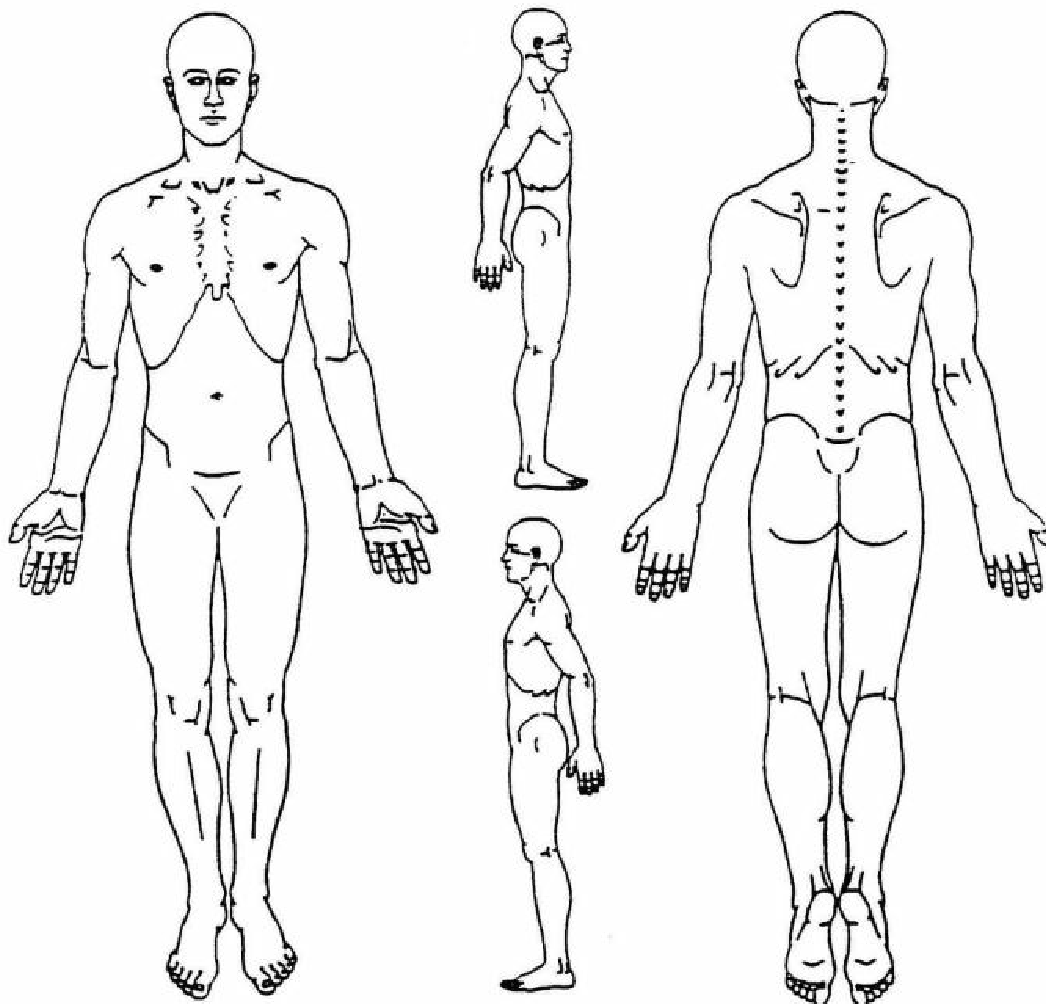
- Improved
- Worse
- Stable

Please indicate if you have any of these concerns:

- Pain
- Decreased Motion
- Swelling/Edema
- Stiffness
- Loss of Function

Please indicate the location of your symptoms:

0 - Sharp 1 - Aching 2 - Numbness 3 - Tingling



What goal(s) do you have for your physical therapy sessions?

____

____

____

____

How would you rate your physical health?

- ○ Excellent
- ○ Good
- ○ Fair
- ○ Poor

Height (ft & in.): ____________________

Weight (lbs.): ____________________

Do you have any of the following?

- ☐ Difficulty sleeping
- ☐ Dizzy/lightheaded
- ☐ Recent Falls
- ☐ Discoordination
- ☐ Vision Changes
- ☐ Hearing Impairment
- ☐ Bladder/bowel changes
- ☐ Sudden weight loss/gain
- ☐ Nausea/vomiting
- ☐ Fever/chills/sweats
- ☐ Numbness/tingling
- ☐ Bleeding problems
- ☐ Pain/swelling in legs
- ☐ Chest pain/angina

Have you ever been diagnosed with the following?

- ☐ Cancer ____________
- ☐ Diabetes ____________
- ☐ Kidney disease ____________
- ☐ Heart problems ____________
- ☐ Thyroid problems ____________
- ☐ Circulation problems ____________
- ☐ AIDS/HIV-positive ____________
- ☐ High blood pressure ____________
- ☐ Tuberculosis ____________
- ☐ Anxiety/Depression ____________
- ☐ Asthma ____________
- ☐ Epilepsy/Seizures ____________
- ☐ Anemia ____________
- ☐ Fibromyalgia/myofascial pain ____________
- ☐ Stroke ____________
- ☐ High cholesterol ____________

List any other major medical conditions or injuries you have/had:

____

____

____

____

Have you had any past surgeries?

- ○ Yes
- ○ No

If yes, list briefly:

___

___

___

___

Medication: List all medications you are taking, including any over-the-counter medications, herbs or vitamins:

	Medication Name	Dosage	Frequency	Reason for taking
1				
2				
3				

Any Allergies?

- Yes
- No

If yes, please list:

___

___

___

___

Do you:	Yes	No	Past
Smoke?			
Drink alcohol?			
Use recreational drugs?			

Activity level:

- Sedentary
- Light
- Moderate
- Active
- Extremely Active