LEVEL HEADED
SPECIALISTS

Intake Form

Disclaimer: Thank you for your interest in being a client of Level Headed Specialists. Information collected about new clients is confidential and will be treated accordingly.

Patient Name
Last: *First:* *MI:*

Preferred Name:

☐ Male ☐ Female Preferred Pronouns**:**

Date of Birth: ____/_____/_____

Address:

Phone Number: Email:

Emergency Contact Info
Name: *Phone*: *Relation*:

Primary Care Physician or Dentist information
Name: *Phone*:

Reason for Physical Therapy:

Ongoing Symptoms:

Have you been treated for this condition before?
☐ No ☐ Yes If yes, by whom?

Was it helpful?
☐ No ☐ Yes

What are your goals for Physical Therapy?

Medications:

Past Surgeries and major injuries
Explanation and date:

Concussion history
Number: *Date(s) of Occurrence*:

Falls history
Number: *Date(s) of Occurrence*:

Have you been diagnosed with any of the following conditions? (check all that apply)

☐ Allergies	☐ Emphysema/Bronchitis	☐ Multiple Sclerosis
☐ Anemia	☐ Fibromyalgia/Chronic Fatigue	☐ Neurological Disorder
☐ Asthma	☐ Fractures	☐ Numbness/Tingling
☐ Bladder/Bowel Problems	☐ Gastrointestinal Problems	☐ On Blood Thinners
☐ Cancer	☐ Gallbladder/Kidney Problems	☐ Osteoporosis/Osteopenia
☐ Cardiac Conditions	☐ Headache/Migraines	☐ Pain Syndrome/CRPS
☐ Pacemaker/Defibrillator	☐ Hepatitis	☐ Parkinson's
☐ Circulation Problems	☐ Hernia	☐ Seizures
☐ Currently Pregnant	☐ High Blood Pressure	☐ Speech Problems
☐ Depression	☐ Incontinence	☐ Strokes
☐ Diabetes	☐ Metal Implants	☐ Thyroid Problems
☐ Dizziness/vertigo	☐ Migraine	☐ Vision Problems

Please describe in detail any diagnosis checked above:

Have you suffered from any illness not listed here?
☐ No ☐ Yes

If yes, please explain:

CONSENT FOR CARE AND TREATMENT

I, the undersigned, hereby agree and give my consent for Level Headed Specialists to furnish physical therapy care and treatment considered necessary and proper in evaluating or treating my physical condition. _____ (Patient initial)

FOR MINORS ONLY: CONSENT FOR CARE:

As parent and/or legal guardian, I authorize the physical therapist named in this document to treat the minor patient named in the attached forms while I am not present. _____ (Parent/Guardian initial)

By signing below, I agree that all of the above information is correct, and that I authorize Level Headed Specialists to provide me with therapy services and to furnish my physician, insurance company or attorney information concerning my injury and treatment.

CLIENT SIGNATURE

Signature: Date:

Print Name: