Dr. Nolan Christopher

Intake Information Form
How did you find out about our facility?

☐ MD ☐ Friend ☐ Previous Patient ☐ Insurance Carrier ☐ Other:

Patient Information and Billing Information

Last First M. Insurance Company Name

Address Claim/ID Number

City State Zip Date of Accident (no-fault and Workers Comp)

Home Phone Cell Phone

Sex M ☐ F ☐

Date of Birth

Employer Work Phone

Email Address:
Your e-mail address will be used for your Home Exercise Program

Referring Physician Phone # Primary Care Physician Phone #

Patient/Guardian Signature: _____

Date: _____

I hereby Authorize G2 Sports and Physical Therapy Access to my Medical Records for the Above Physician/'s

In case of an Emergency, please contact: (*list a friend or relative that can be reached during office hours)*

Name: _____

Phone: _____ Relationship: _____

Dr. Nolan Christopher

Are current symptoms related to: ☐ Auto Accident; If so, has the accident been reported? ☐ Yes ☐ No

State of Accident_____

☐ Work Injury; If so, is there a case manager involved? ☐ Yes ☐ No

Date of Accident: _____

_____

Case Manager Name Phone # Fax #

_____

Employer Contact/Title: Phone # Fax #

_____

Diagnosis (es): Date of last MD Appt: Date of Next MD Appt:

Date of Onset/Injury: _____ Rx Date

Surgery: ☐ Yes ☐ No Date of Surgery:

Dr. Nolan Christopher

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____ (*printed name of patient or personal representative*) acknowledge that I have received a copy of the Notice of Privacy Practices of **Dr. Nolan Christopher** for (*check one*) _____ me specify name of individual_____ [*please print clearly*] and agree to the liability limitations explained therein.

_____

Signature of Patient or Personal Representative Date

_____

Print Name Relationship to patient (not self)

CONSENT TO TREAT

I voluntarily give Dr. Nolan Christopher my consent to receive services which may include diagnostic procedures, examinations, and treatment according to the recommended plan of treatment as discussed with my therapist. I understand that physical therapy involves manual techniques that require appropriate physical contact by the health care provider and staff.

I have read (or have had read to me) the above information and understand the content.

_____

Patient (or Guardian) Signature Date

INITIAL EVALUATION SUBJECTIVE HISTORY WORKSHEET (Page 1)

Patient Name: _____ DOB: _____ Date of Eval: _____

Describe the current problem that brings you here today: _____

When did your symptoms start? _____

Are your symptoms: ☐ Improving ☐ Getting Worse ☐ Staying the Same

Have you had any testing ☐ X-rays ☐ MRI ☐ EMG/ Nerve Conduction Test ☐ CT Scan ☐ Other : _____

Results (please provide report, or contact information for report): _____

Have you ever had these symptoms before? ☐ Yes ☐ No Description: _____

Did you have surgery for this issue? ☐ Yes ☐ No Date of Surgery: _____

If Yes, what procedure did you have done? _____

Have you ever had treatment for these symptoms? ☐ Yes ☐ No If YES, please describe:

☐ Medication: Beneficial? ☐ Yes ☐ No Explain: _____

☐ Injection: Beneficial? ☐ Yes ☐ No Explain: _____

☐ Physical Therapy : Beneficial? ☐ Yes ☐ No Explain: _____

☐ Massage/Chiropractic: Beneficial? ☐ Yes ☐ No Explain: _____

CURRENT COMPLAINTS

If you have pain, what is your pain level?

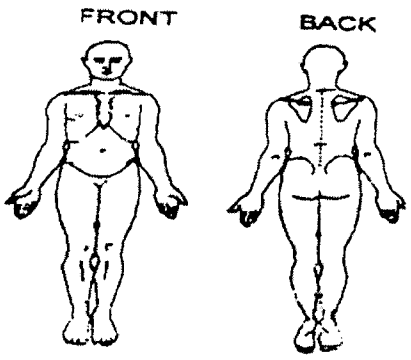
(0 = No Pain, 10 = Extreme Pain – Circle)

AT WORST: 0 1 2 3 4 5 6 7 8 9 10

AT BEST: 0 1 2 3 4 5 6 7 8 9 10

CURRENTLY: 0 1 2 3 4 5 6 7 8 9 10

Mark the location of your pain with an "X":



Describe symptoms:

☐ Constant ☐ Come and Go ☐ Ache ☐ Deep ☐ Superficial ☐ Dull ☐ Sharp ☐ Shooting ☐ Burning ☐ Numb/Tingling

☐ Other: _____

Symptom Pattern:

Does your pain seem to be WORSE at a certain time of day? ☐ Yes ☐ No

If Yes, ☐ Morning ☐ Night ☐ Other: _____

Does your pain progress as the day goes along? ☐ Yes ☐ No If Yes, please explain: _____

Do you have difficulty sleeping? ☐ Yes ☐ No If Yes, please explain: _____

Do you wake due to pain? ☐ Yes ☐ No If Yes, # of times per night: _____

FUNCTIONAL ABILITIES AND RESTRICTIONS

What activities or duties are difficult to perform due to your condition? ☐ Squatting ☐ Sitting ☐ Standing ☐ Walking ☐ Lifting

☐ Dressing/Grooming ☐ Driving ☐ Stairs ☐ Reaching ☐ Work Tasks ☐ Gripping/Pinching ☐ Kneeling ☐ Position Changes

☐ Cooking ☐ Cleaning ☐ Vacuuming ☐ Laundry ☐ Yard Work ☐ Shopping ☐ Exercise: _____

☐ Other: _____

What makes your pain WORSE? _____

What makes your pain BETTER? _____

Occupation: _____ Presently Working: ☐ Yes ☐ No If Yes, ☐ Full Duty ☐ Limited Duty:

Restrictions: _____ # Days Off Work: _____ Job Duties: _____

Are you now, or have you ever been disabled? ☐ Yes ☐ No If Yes, when? _____ Please explain: _____

Have you had any falls in the past 12 months? ☐ Yes ☐ No If Yes, how many times? _____ Injuries? _____

What is your current living arrangement? ☐ Alone ☐ Spouse ☐ Partner ☐ Family ☐ Other: _____

Does your home have stairs? ☐ Yes ☐ No If Yes, # of stairs: _____

If Yes, do your stairs have a handrail? ☐ Yes ☐ No If Yes, which side going up? ☐ Right ☐ Left ☐ Both

Do you use an assistive device? ☐ None ☐ Cane ☐ Walker ☐ Wheelchair ☐ Other: _____

INITIAL EVALUATION SUBJECTIVE HISTORY WORKSHEET (Page 2)

Patient Name: _____ DOB: _____ Date of Eval: _____

PREVIOUS MEDICAL HISTORY

How would you classify your general health? ☐ Good ☐ Fair ☐ Poor

Current Height: _____ Current Weight: _____

In terms of your general health, please check ALL that apply:

- ☐ Allergies
- ☐ Rheumatoid Arthritis
- ☐ Metal Implants
- ☐ **Recent Headaches**
- ☐ **Recent Vision Changes**
- ☐ Sexual Dysfunction
- ☐ Osteoarthritis
- ☐ Heart Palpitations
- ☐ Chest pain/Angina
- ☐ Stroke /TIA
- ☐ Physical Abnormalities
- ☐ Hypoglycemia
- ☐ **Night Pain**
- ☐ Urine Leakage
- ☐ Kidney Problems
- ☐ Anemia
- ☐ **Recent Fever**
- ☐ **Ringing of the Ears**
- ☐ **Recent Nausea/Vomiting**
- ☐ Heart Attack
- ☐ **Cancer**
- ☐ Skin Abnormalities
- ☐ Osteoporosis
- ☐ Hernia
- ☐ Depression
- ☐ Surgeries
- ☐ Polio
- ☐ Intolerance to Cold/Heat
- ☐ Recent Fractures
- ☐ Heart Disease
- ☐ Liver/Gallbladder Problem
- ☐ Fibromyalgia
- ☐ Asthma/Breathing Difficulties
- ☐ Seizures/Epilepsy
- ☐ **Recent Dizziness/ Fainting**
- ☐ **Recent Change in Bowel/Bladder Habits**
- ☐ **Pain with Cough/Sneeze**
- ☐ Smoking History
- ☐ Pacemaker
- ☐ High/Low Blood Pressure
- ☐ Diabetes I or II
- ☐ **Unexplained Weight Loss/Gain**
- ☐ Pregnancy (Currently)
- ☐ **Recent Unexplained Fatigue**
- ☐ **Numbness/Tingling in Hip/Buttocks Area**

Is there any other information regarding your medical history or are there any factors that may complicate your ability to participate in therapy that we should know about? _____

MEDICATIONS

Please list all of the medications [*with specific NAME, DOSAGE, FREQUENCY, and ROUTE (ie: by mouth)*] that you are currently taking [including over-the-counter, prescriptions, herbals, and vitamins/mineral(s)]:

_____

_____

_____

_____

Are you currently taking blood thinners/anticoagulants? Yes No

If yes, how long and for what condition_____

PATIENT GOALS FOR THERAPY

What are your goals for participating in Therapy?

1. _____
2. _____
3. _____

SIGNATURES

To the best of my knowledge I have fully informed you of the history of my problem and current status.

Patient's Signature: _____ **Date:** _____

Therapist's Signature: _____ **Date:** _____

THERAPIST COMMENTS: _____