Wisconsin Orthopedic Physical Therapy
Patient Intake Form

Name:_____
Address:_____
City:_____ **State:** _____ **Zip Code:** _____

Date of Birth: _____ **Sex** (circle): Male Female

Email:_____

Home Phone:_____

Cell Phone:_____

Best number to be reached at (circle): Home Cell

Employer:_____

Occupation:_____

What made you choose Wisconsin Orthopedic Physical Therapy? (circle)

Website Doctor Family/Friend Employer Insurance I'm a Returning Patient

If Family/Friend, please list for Referral Program: _____

Referring Physician:_____ Date of next appointment:_____

Primary Care Physician:_____

Person to notify in case of emergency:

Name:_____ Phone: _____

For Office Use Only

Case:	
ICD10 Code:	

Medical History

Are you allergic to latex? (circle): Yes No
Do you use tobacco? (circle): Yes No
Have you recently been hospitalized or had surgery? (circle): Yes No
If yes, explain: _____
List any medications you are currently taking: _____

For Medicare Only: *Height:* _____ *Weight:* _____

Do you now or have you ever had the following conditions? (check all that apply)

- ☐ Arthritis
- ☐ Asthma (circle one: controlled or uncontrolled?)
- ☐ Cancer
- ☐ Cardio/Vascular problems
- ☐ Halter monitor
- ☐ High blood pressure (circle one: controlled or uncontrolled?)
- ☐ COPD (circle one: controlled or uncontrolled?)
- ☐ Currently pregnant
- ☐ Diabetes (circle one: controlled or uncontrolled?)
- ☐ Dizziness/Fainting
- ☐ Fractures
- ☐ Headaches
- ☐ Hepatitis
- ☐ HIV
- ☐ Kidney problems
- ☐ Low blood pressure
- ☐ Pacemaker
- ☐ Respiratory problems
- ☐ Seizures (circle one: controlled or uncontrolled?)
- ☐ Thyroid problems
- ☐ Other condition: _____
- ☐ None of the above apply

Consent to Treat: The signature below authorizes Wisconsin Orthopedic Physical Therapy to perform physical therapy services.

SIGNATURE OF PATIENT: _____ DATE:_____
Reviewed by Therapist:_____
This form must be completed in its entirety and must be provided to Wisconsin Orthopedic Physical Therapy prior to initiation of therapy services.