



Physical Therapy for Pelvic Pain, Incontinence, Infertility and Gastrointestinal Disorders
16618 W 159th St, Units 401 & 402, Lockport, IL 60441 Phone: (815) 838-0529 Fax: (815) 838-0652 Website: kc4hl.com

PATIENT INTAKE FORM

Name: Referral Date:
Address: City: State & Zip:
Home Phone: Cell Phone: Work Phone:
SS#: Date of Birth: E-mail:
In case of emergency, contact: Phone:
How did you hear about us:
Have you received any home health care within the past six months? YES NO
Referring Physician: City: Phone:
Is there someone else that you would like us to send this information to?
Physician: City: Phone:
Diagnosis / Complaint:

RESPONSIBLE PARTY / PARENT / LEGAL GUARDIAN (if applicable)

Name: Relationship:
SS#: Date of Birth: Phone:
Address: City: State & Zip:

EMPLOYER INFORMATION

Employer Name: Occupation:
Address:
Phone: Contact Person: Attorney:

PAST SURGERIES

Description: Date:
Description: Date:
Description: Date:
Description: Date:

PAST CONDITIONS / DISEASES / INJURIES / INFECTIONS

Description: Date:
Description: Date:
Description: Date:
Description: Date:

MEDICATIONS

Description: Date Started:
Description: Date Started:
Description: Date Started:
Description: Date Started:

Allergies:

Date of last pelvic / prostate exam: Results:

Date of last mammogram: Results:

Date of last dexascan / bone density test: Results:

Date and results of any other recent tests:

Activity level / work / hobbies:

Severity of this condition (0=NO PROBLEMS - 10=UNBEARABLE):

Your goal from physical therapy: