Kirk Center for Healthy Living
Therapy for Pelvic Pain, Incontinence, Infertility and Gastrointestinal Disorders

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Phone: **(815) 838-0529** ❖ Fax: **(815) 838-0652**
Website: **kc4hl.com**

Patient Intake Form

Name: _____ Referral Date: _____ Height: _____ Weight: _____

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: _____

OTHER INFORMATION

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 therapy: _____

_____