



Physical Therapy for Pelvic Pain, Incontinence, Infertility and Gastrointestinal Disorders

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PATIENT INTAKE FORM

Name: Referral Date:

Address: City: State & Zip:

Home Phone: Work Phone: Cell Phone:

SS#: DOB: E-mail:

In case of emergency, contact: Phone Number:

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:

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 dexa scan / 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: