Anchor Physical Therapy, Pllc - Intake Form

Name: _____ DOB: _____

Address: _____

Phone: _____ Best time to call? _____

Would you like an appointment reminder (via text): Yes ☐ No ☐

Alternate Phone: _____ Email: _____

May we send emails about practice announcements, events, or marketing? Yes ☐ No ☐

Emergency Contact: _____ Relationship: _____

Phone Number: _____

Employer: _____ Job Title: _____

Referring Physician: _____ Next Appointment? _____

How did you hear about Anchor PT? _____

Please provide the office with your insurance card and photo ID. Thank you.

Medical History:

Please let us know if you have any of the following conditions:

Y	N	Cancer: _____	Y	N	Migraines/Headaches
Y	N	High Blood Pressure	Y	N	Multiple Sclerosis
Y	N	Heart Problems: _____	Y	N	Rheumatoid Arthritis
Y	N	Pulmonary Issues	Y	N	Osteoarthritis
Y	N	Diabetes	Y	N	Osteopenia/Osteoporosis
Y	N	Circulation Problems	Y	N	Anxiety/Depression
Y	N	Thyroid Problems	Y	N	Tuberculosis
Y	N	Chemical Dependency	Y	N	Hepatitis
Y	N	Stroke	Y	N	Epilepsy
Y	N	Arnold Chiari	Y	N	Kidney Disease/Anemia
Y	N	Concussion/TBI	Other: _____		

Hospitalizations:

_____ Date: _____ _____ Date _____

Recent Injuries:

_____ Date: _____ _____ Date _____

If you are taking any medications please write on the back of this form or provide the office with a list. Thank you.

Have you recently noted any of the following (circle any that apply)? Numbness/Tingling, Fevers/Chills/Sweat, Unexpected Weight Loss/Gain, Fatigue, Lightheadedness