2250 NW Flanders St. Ste G01
Portland, OR 97210
p: (503) 847-8550
f: (971) 213- 4030

New Patient Intake Form

Patient Information:

Date of Initial Evaluation:

Legal Name:	I prefer to go by:
Date of Birth:	Age today:
Billing Address:	
City / State / ZIP:	
Phone #:	
Email:	
I prefer visit reminders by:	*(underline your preference):* Email Text Phone Call No Thanks, I'll remember.

Insurance Information: *(please fill out the pertinent information below so we can help you recover your payments.)*

Insurance to be billed:	
Insurance Company's Billing Address:	
City / State / ZIP:	
Group #:	
Subscriber ID#:	
Insurance Company Phone Number:	

Basic Background Information:

Reason for Visit:	
How did you hear about Physio PDX?	
Have you received treatment for this issue in the past? *(If so, what have you tried, and did it help?)*	
Please briefly mention any previous surgeries, car accidents or sport related histories, and roughly what year they occurred:	
Medications/Supplements and doses of each you are currently taking:	
Please list any Current Medical Conditions/diagnoses you have:	

General Health Screening Questions:

Please mark any of the following symptoms you have experienced in the last 2-4 weeks, and answer any follow up questions relevant to your condition.

<table>
<tr>
<td>Dizziness
Double vision
Difficulty speaking
Difficulty swallowing
Nausea
Irregular eye movements
Tinnitus (ringing in your ear/s)
Tingling/numbness in the face
Light and/or sound sensitivities</td>
<td>Headaches:
Are your headaches present all the time, or do they come and go?
On average, where are most of your headache symptoms located?
If they are in more than one region, does the headache in one location, trigger the other location to hurt, or does the headache just move around (i.e. sometimes it’s in spot 1, and sometimes it’s in spot 2?)
On average, how long do your headaches typically last?
What is the typical intensity of worst headache symptoms you have (0/10-10/10)?
What types of things seem to trigger your headaches to start or worsen?
If anything, what do you find helpful to reduce your headaches?</td>
</tr>
<tr>
<td>Difficulty finding a position of relief
Pain at night limiting ability to sleep
Night sweats
Fever/ chills /body aches
Recent unexplainable weight loss of more than 10lbs in a month</td>
<td rowspan="2">Jaw Symptoms:
Please list any diet changes you have made because of this problem:
Pain with Yawning:
Pain with initial movement in AM after sleeping:
Pain/fatigue or both in jaw with talking:
Do you wear any type of mouth device for tooth protection, bite alignment, or sleep apnea? If yes, how often, and for how long have you been using this device?
Do you have a history of braces use? If so, when and for how long:
Have you had any locking of your jaw? Do you lock open or closed?
Does your jaw make any popping or clicking noises, and if so, do you experience pain during that noise?
Have you noticed any change to your sensation in your facial region?
List any other symptoms you have noted that you think are related to your jaw problems:</td>
</tr>
<tr>
<td>Simultaneous tingling or numbness in both hands, both feet, or both hands and feet together
Weakness in your hands or lower extremities you can’t explain
Clumsiness with your fingers or tripping over your feet
Changes in sensation in your hands or feet</td>
</tr>
<tr>
<td>Are you afraid of falling?
Have you fallen more than 2 times in the last 12 months?
How did it happen?
Did you need medical care for injuries you sustained from the fall?</td>
<td>Any changes to your bowel or bladder function? (including ability to start or stop the flow of urine, or fully void your bowels during a bowel movement).
Any changes to the sensation of your saddle region (can you sense everything when you toilet, or wash yourself while bathing and dressing?)</td>
</tr>
</table>

Personal History & Goals:

What do you enjoy doing for fun?	
What do you do for work? If you are not employed, what do you do with your body in an average day?	
How would you rate your general stress level if 0 is no stress, and 10/10 is extreme?	
List any current mental health or relationship stressors you are currently dealing with in your life	
What are your top three goals/priorities for coming in to Physio PDX (what do you want to achieve by coming in for treatment?)	1) 2) 3)

By Signing below, I hereby give my consent to be physical evaluated within the limits of the law and scope of practice of Physical Therapy.		
Patient Signature:		
Therapist Signature:	Place of Service: #	Physio PDX, LLC
	License #	60490
Sarah H. Stuhr, PT, DPT, FAAOMPT	Tax ID/EIN:	81-3366040