SYNERGY
Physical Therapy & Performance

Intake Sheet

Name________________________________
Address_____________________________
____
City_______________________________
State _______ Zip______________________
Phone ______________________________
Email ______________________________
Would you like **email** appointment reminders? ☐Yes ☐No
Date of Birth ______________________
Social Security # ___________________
Marital: ☐M ☐S☐ W ☐D
Gender: ☐M ☐F
Employer _________________________
Address___________________________
Emergency Contact Name & Number
____

Payment is expected at time of visit ☐Cash ☐Check ☐Credit/Quick Pay
Person Responsible for Payment (if same as patient leave blank)
Name______________________________
Phone______________________________
Address_____________________________
City_______________________________
State______ Zip_______________________

Are you insured? ☐Yes ☐No Insurance Company__________________________

Is this a work related or auto accident injury? ☐Yes ☐No

If Yes, do you have an attorney?
☐Yes ☐No
Attorney Name____________________
Attorney Number __________________

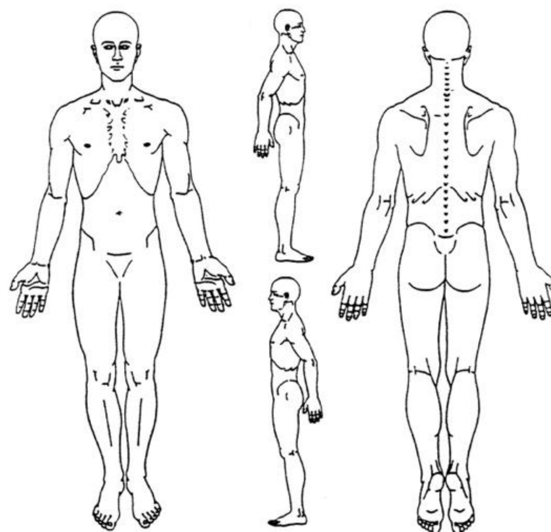
Date of Injury _____________________

Date of Surgery ___________________

Please rate your current pain level
1 2 3 4 5 6 7 8 9 10 10+

Please indicate where symptoms are present and nature of symptoms:

Pain/Aching: xxxx
Numbness/Tingling: ****
Burning: oooo



Medical History:

- High Blood Pressure
- Heart Disease
- Pacemaker
- Diabetes I or II (circle numeral)
- Cancer
- Depression
- Pulmonary Disease:
  ____
- Neurological Disease:
  ____
- Surgeries and year performed:
  ____
  ____
- Current Medications:
  ____
  ____