BIOKINETIC
PHYSICAL THERAPY

7 W 22nd St, Fl 8, New York, NY 10010
+1917 400 2082

Physical Therapy Intake Form Packet

Name: *First Name* *Middle Name* *Last Name*

Preferred Name: *Preferred Name* **Sex:** *M/F/Other*

Social Security Number: **Date of Birth:** *MM/DD/YY*

Email Address: **Cell Phone:**

Address: *Address* *City* *State* *Zip*

Apt/Suite: *Apt/Suite* **Marital Status:** Select

Referring Physician's Name: *First Name* *Last Name*

When was your last physician visit? *MM/DD/YY* **Was this an auto accident?** ◯ YES ◯ NO

Was this a work related accident? ◯ YES ◯ NO **Date of Accident:** *MM/DD/YY*

Do you have an attorney? ◯ YES ◯ NO

Tell us about your injury.

How did you hear about us? *Online, word-of-mouth, etc.* Select

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Emergency Contact

	First Name	*Last Name*	*Relationship*
Emergency Contact:			

	Home
Primary Phone:	

Responsible Party Information

Is the patient a minor? ◯ YES ◯ NO

Responsible Party Employer

	Full Name		*Phone*
Employer Name:		**Employer Phone:**	

Patient or Spouse Employer

	Full Name		*Phone*
Employer Name:		**Employer Phone:**	

Medical History

	Name / Practice		*Name / Practice*
Family Physician:		**Referring Physician:**	

	MM/DD/YY
Date of 1st MD visit for this injury:	

Was this a result of a motor vehicle or work comp related injury? ◯ YES ◯ NO

Have you had surgery for this injury? ◯ YES ◯ NO

Please list all prescription and non-prescription medication you are currently taking.

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Do you now have or have you ever had any of the following:

Please check the appropriate answers

- ☐ Asthma, Bronchitis, or Emphysema
- ☐ Shortness of Breath
- ☐ Chest Pain / Angina
- ☐ Coronary Heart Disease
- ☐ Pacemaker
- ☐ High Blood Pressure
- ☐ Heart Attack or Heart Surgery
- ☐ CVA (Stroke) / TIA (Mini Stroke)
- ☐ Blood Clot / Emboli
- ☐ Epilepsy / Seizures
- ☐ Thyroid Dysfunction / Goiter
- ☐ Anemia
- ☐ Infectious Diseases
- ☐ Diabetes
- ☐ Cancer / Chemotherapy / Radiation
- ☐ Arthritis / Swollen Joints
- ☐ Osteoporosis
- ☐ Gout
- ☐ Sleep Disorders
- ☐ Emotional / Psychological Problem
- ☐ Bowel and/or Bladder Dysfunction
- ☐ Severe of Frequent Headaches
- ☐ Vision or Hearing Difficulties
- ☐ Dizziness or Fainting
- ☐ Numbness or Tingling
- ☐ Weakness
- ☐ Unexpected Weight or Energy Loss
- ☐ Hernia
- ☐ Varicose Veins
- ☐ Allergies
- ☐ Any Pins or Metal Implants
- ☐ Joint Replacement
- ☐ Neck Injury
- ☐ Neck Surgery
- ☐ Shoulder Injury
- ☐ Shoulder Surgery
- ☐ Elbow / Hand Injury
- ☐ Elbow / Hand Surgery
- ☐ Back Injury
- ☐ Back Surgery
- ☐ Knee Injury
- ☐ Knee Surgery
- ☐ Leg / Ankle / Foot Injury
- ☐ Leg / Ankle / Foot Surgery

Do you smoke? ◯ YES ◯ NO

Are you pregnant? ◯ YES ◯ NO

Please provide us with any other information that would assist us in your care

What are your expectations while in this program?