Intake Form

Brian Cox PT & Chiro

Brian Cox, Physical Therapist & Chiropractor
4164 N Buffalo Rd, Orchard Park, NY 14127 Phone: 716-662-1514

Name: _____ ☐ Male ☐ Female Date:_____

Address: _____ City:_____ Zip:_____

Home/Cell Phone: _____ Date of Birth: _____ Age: _____

E-Mail (to receive your exam and exercises):_____

Primary Doctor: _____ Your Insurance Plan: _____

Occupation: _____ Who introduced you to us? _____

What is the main reason for this visit: Circle the number of average intensity for this problem:

1. _____ (none) 0 . 1 . 2 . 3 . 4 . 5 . 6 . 7 . 8 . 9 . 10 (worst ever)

2. _____ (none) 0 . 1 . 2 . 3 . 4 . 5 . 6 . 7 . 8 . 9 . 10 (worst ever)

How much of the day is it present? ☐100% ☐75% ☐50% ☐25% ☐less than 25%

What was the onset of main problem: ☐Unknown ☐Fall ☐Lifting ☐Other:_____

Did this current episode start from a recent car accident or work injury? ☐ no ☐yes If yes, tell us now.

When did the current episode start? (approximate date) _____

What is this problem limiting? ☐Sitting ☐Standing ☐Walking ☐Stairs ☐Driving ☐Exercising

What relieves this problem? ☐Sitting ☐Standing ☐Walking ☐Lying Down

Have you ever had this before? ☐No ☐Yes How many times? _____

Have you had any tests for this? ☐X-Ray ☐MRI ☐CT ☐EMG ☐None
Which facility?_____ When?_____ Do you have them?☐No ☐Yes

Have you had physical therapy for this current problem? ☐No ☐Yes When?_____ How many visits?____

Have you had chiropractic care for this current problem? ☐No ☐Yes When?_____ How many visits? ____

Have you ever had a Workers Comp injury? ☐No ☐Yes When? _____ Body Part?_____

Do you exercise regularly? ☐No ☐Yes What is it?_____

Do you have any questions about treatment? ☐No ☐Yes What? _____

Besides less pain, what specific health goals do you want help with?

_____

What type of treatment are you looking for? ☐Physical Therapy ☐Chiropractic ☐Recommendation

_____

Complete Your Health History: List all problems: Circle **L** = Left **R** = Right **B** = Both

☐ Heart problems ☐ No ☐ Yes explain:_____
☐ Cancer ☐ No ☐ Yes type:_____
☐ Osteopenia ☐ Osteoporosis ☐ No ☐ Yes
☐ Whiplash ☐ No ☐ Yes How many:_____
☐ Concussion ☐ No ☐ Yes How many:_____
☐ Headache ☐ No ☐ Yes How many:_____per week/month
☐ Neck ☐ arthritis/degenerative disc ☐disc bulge/herniation ☐ surgery _____
☐ Upper/midback ☐ arthritis/degenerative disc ☐disc bulge/herniation
☐ Low back ☐arthritis/degenerative disc ☐disc bulge/herniation ☐ surgery _____
☐ Shoulder: L R B ☐ arthritis ☐_____ ☐ surgery _____
☐ Hip: L R B ☐ arthritis ☐_____ ☐ surgery _____
☐ Knee: L R B ☐ arthritis ☐_____ ☐ surgery _____
☐ Ankle: L R B ☐ arthritis ☐_____ ☐ surgery _____
☐ Foot: L R B ☐ arthritis ☐_____ ☐ surgery _____

☐ Other Major Health Conditions/surgeries ☐No ☐ Yes
explain:_____

Authorization and Release:

I authorize my insurance benefits to be paid to Brian Cox PT, DC.

I consent to release related diagnostic reports to Brian Cox PT, DC.

I have been provided an opportunity to review the Notice of Privacy Practices.

I acknowledge that I am financially responsible for all fees not covered by insurance.

I authorize Brian Cox, PT, DC for treatment of my minor child
(Print)_____(Sign)_____.

_____
Patient/Parent Signature