New Patient Intake Form

SPECTRUM THERAPY & WELLNESS

Please arrive 15 minutes prior to your appointment time on your first visit

Name: ____
Date:_________________________

When is your next appointment with this doctor?
____

What is your primary complaint?
____

Around what date did you begin experiencing this issue?
____

If this is a result of an injury, how and when did this injury occur?
____

____
___

Have you had surgery, or do you have surgery scheduled because of this injury?
YES__________NO__________

If yes, what is the surgery date? _________________ What surgery did you/will you have?
____

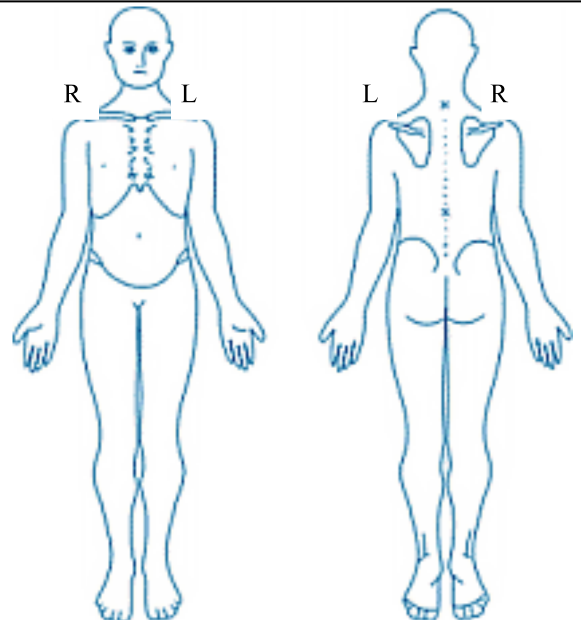
If this is a Worker's Comp claim, have you already had Physical Therapy for this claim? YES_____
NO________

Is this injury a result of a motor vehicle accident? YES_____ NO________

Over the past 24 hours, how bad has your pain been?

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Imaginable Pain

Please Indicate the location of your pain to the right ⟶



Is there anything else we should know about your pain?

____

____

____

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Please list 2 GOALS you wish to achieve from participating in therapy.

1. ____

2. ____

Health History

Yes No Do you have any known allergies? If yes, please list________________________________

Yes No Do you currently take medication? If yes, please list________________________________

____

Yes No Have you had any previous surgeries or broken bones? If yes, please list____________________

____

Yes No Have you fallen during the past year or ever fallen and suffered an injury as a result?

If yes, please explain. ____

Yes No Are you currently residing in a skilled nursing facility or receiving Home Health care?

Have you had or do you now have any of the following?

condition	yes	no	year
neck or back pain /injury			
arthritis			
fainting or dizzy spells			
frequent headaches or migraines			
epilepsy or seizures			
heart disease or heart surgery			

condition	yes	no	yea r
peripheral arterial disease			
diabetes			
low blood sugar			
pulmonary disease			
shortness of breath			
cancer			

7442 Frank Ave NW • North Canton Ohio 44720
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Updated 6/20/2019

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High/low blood pressure (circle One)				autoimmune disease (hepatitis, aids, etc)			
stroke				pacemaker implant			
osteoporosis or osteopenia				neurotransmitter implant			
hernia(s)				hearing problems			
Surgery past 3 months				Uncontrolled anticoagulant use			
Pregnant or possibly pregnant				Compromised immune system			
Local or systemic infection				Metal allergies			
Active tumor							

Is there anything else we should know prior to the start of your therapy treatment?

____

____

Patient Signature: ____ Date: _____/_____/_____

Therapist Signature: ____ Date: _____/_____/_____

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