TruMotion Physical Therapy
1 Main Street, Suite 107, Eatontown NJ 07724
P: (732) 334-6741
F: (732) 913-3174

Intake Form

Name_____Date_____
Address_____City_____State_____Zip_____
Date of Birth_____Age_____Gender_____Marital Status_____
Social Security Number_____Occupation_____
Work Status_____
Phone (Home)_____Phone (Cell)_____Phone (Work)_____
Email Address_____
Preferred Method of Contact_____

Emergency Contact Information
Name_____Relationship_____
Address (if different)_____City_____State_____Zip_____
Occupation_____Phone (Home)_____Phone (Cell)_____

How did you hear about TruMotion Physical Therapy?
__Physician_____ __Website
__Family/Friend_____ __Visibility
__Insurance __Other_____

Physician Information
Name of referring physician_____
Address_____City_____State_____Zip_____
Phone_____Fax_____

Insurance Information
Primary Insurance
Name of Insured_____Relationship to patient_____
Date of Birth_____Employer_____Social Security_____
Insurance Carrier/company_____Insurance Plan_____
Policy#_____Group#_____
Address_____City_____State_____Zip_____
Phone_____

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Secondary Insurance
Name of Insured_____Relationship to patient_____
Date of Birth_____Employer_____Social Security_____
Insurance Carrier/company_____Insurance Plan_____
Policy#_____Group#_____
Address_____City_____State_____Zip_____
Phone_____

Medical History

Height_____Weight_____Allergies_____
_____

Have you ever been diagnosed with the following (Please circle all that apply)

Arthritis	Rheumatoid Arthritis	Joint Replacement
Diabetes	Chemical Dependency_____	Kidney Disease
High Blood Pressure	Pacemaker	Thyroid Disease
High Cholesterol	Osteopenia/Osteoporosis	Asthma
Cancer_____	Hepatitis (A B C)	Vision Difficulties
Stroke/TIA	Headaches	Hearing Difficulties
Heart Attack	Glaucoma	Emphysema/COPD
Fibromyalgia	HIV/AIDS	Incontinence
Depression	Abnormal Bleeding	Seizures/Epilepsy

Are you pregnant? (YES/NO)

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Have you recently experienced

Difficulty speaking/swallowing	Night pain
Double vision	Fever/chills/sweats
Numbness	Fatigue
Unexplained weight loss	Falls/drop attacks
Difficulty walking/poor coordination	Vertigo

Medications
Please list all current medications

Medication	Dosage	Route (ie:orally)	Frequency

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Reason for visit

Describe what may have caused this condition

_____
_____
_____

Describe your symptoms

_____
_____
_____

How is this condition affecting your function

_____
_____
_____

Is there any other information you would like to provide about your condition?

_____
_____
_____

Have you had any imaging studies? X-ray____ MRI____ CT____ Other_____

Are you currently experiencing pain?(YES/NO) Location(s)_____
How long have you had pain?_____ Have you had this pain before? (YES/NO)

On a scale of "0" to "10" where 0 = no pain and 10 = worst pain imaginable, please rate the following

Pain now_____ Pain at its worst_____ Pain at its best_____

Describe your pain (sharp/stabbing/aching, etc)

_____

Describe what makes your pain

Better_____
Worse_____

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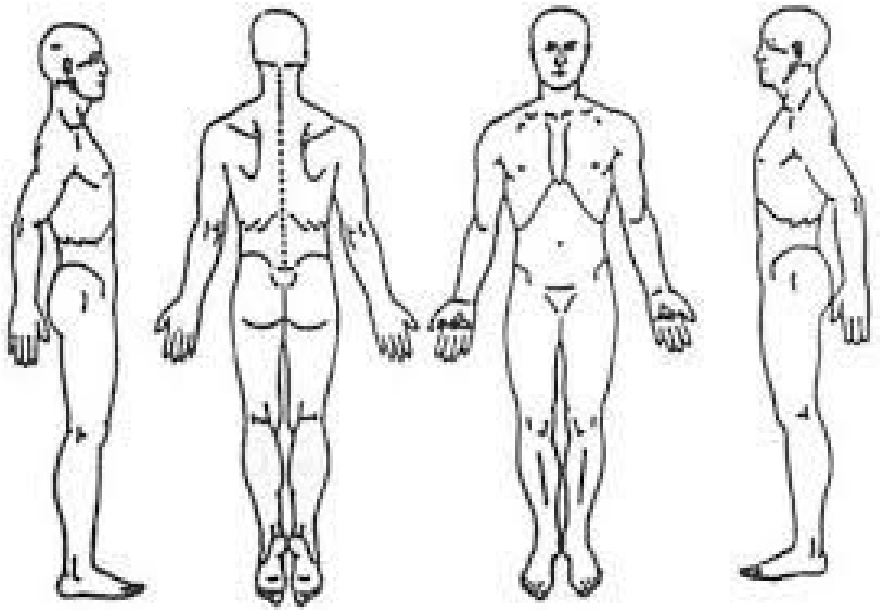
Does your pain appear to be getting (Circle one) BETTER WORSE STAYING THE SAME

Mark the areas on the body diagram that you are experiencing symptoms



Rehabilitation Services

Have you had physical therapy services for the same condition this year? YES NO

Are you currently receiving home health services? YES NO

Have you been discharged from a rehabilitation facility or skilled nursing facility? YES NO