

PATIENT INTAKE FORM

Please complete these intake forms before your first appointment and return them via email. Please reach out with any questions, and we look forward to meeting you.

Name	Date of Birth
Address	Emergency Contact Phone
Phone	Relationship to Patient
E-mail	
Referring Doctor	Phone
Consent	to the following
Text Messages Yes No	Clinic Information E-mails Yes No
Voicemail Yes No	Marketing E-mails Yes No
Mobile Carrier	
Healt	h Information

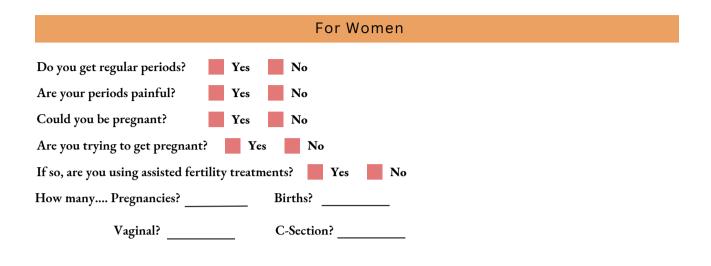
Current Concern(s):

Do	o you get regular physicals? Yes No
Do	o you feel like you're in generally good health? Yes No (Please discuss with therapist)

What medications do you take and please include frequently used dietary supplements and non-prescription medications? You may also bring a pre-printed list.



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Health History

**Check and describe any health conditions you experience(d).



Surgical History

Have you ever had surgery?

Yes No

Please list all past surgeries including dates.



Do you feel safe from violence, coercion, and abuse at home? Yes No

If not, we can direct you to social service agencies that can assist you. It's safe to tell us.

We will rely upon the information you have provided in treating you. By signing below, you attest that this information is accurate to the best of your knowledge.

Patient Name:

Patient/ Guardian Signature:

Date: