Laking Therapy Services LLC
101 Log Canoe Circle, Ste C4
Stevensville MD, 21666
410.643.4197

Patient Intake Form

Date: _____

Patient Name: _____ Date of Birth: _____

Home address: _____ Occupation:_____

City/State: _____ Company name: _____

Zip: _____ Work address:_____

City/State/Zip: _____

Home Phone # _____ Work Phone # _____

Cell Phone # _____

Emergency contact name & telephone #_____

Referred to this office by: _____

How did you hear about this office (if different from referral source): _____

Name of primary care physician: _____

Address: _____

_____Phone # _____

Permission to release treatment records to requesting parties?

_____ *(sign and date)*

Patients are responsible for payment for missed appointments or appointments canceled within 24 hours prior to scheduled time.

Laking Therapy Services LLC

Patient Name:_____ Date of First appointment:_____

1. Describe your injury/accident in as much detail as possible including position your body was in just prior to being injured, what happened during the incident in which you were injured, and what position you were in after the incident. If it was an automobile accident, please state if you were wearing lap and shoulder belts, and if any airbags inflated.

2. Are your symptoms sharp or dull; aching or burning; numb or tingling; constant or intermittent; on the surface or deep; worse during the day or night, etc.? Describe what you feel in any way that makes sense to you.

3. What makes your symptoms worse?

4. What makes them better?

5. What is your chief complaint (if different from above)?

6. What would you like to achieve in treatment? List as many specific goals as you would like.

7. What activities are you having a difficult time performing as a result of your symptoms?

8. Have you had any diagnostic tests performed regarding your present complaints, for example X-rays, MRIs, CAT scans, EMG/nerve conduction velocity tests, etc.? If so what were the results? (If possible please bring in the films and any written reports of results.)

9. List any significant past medical history including previous surgeries (please indicate the location and size of any scars), major injuries, fractures, heart disease, lung disease, diabetes, cancer, thyroid irregularities, infectious disease of any kind.

10. List any pills or medications you are taking (please include vitamins and over-the-counter medications such as aspirin, Advil, Tylenol, etc.)

11. What if anything do you have to give up to get well?

12. Do you currently or occasionally see, hear, or smell strange or unusual things? If yes, please describe them.

13. If you are female and pre-menopausal, are your menstrual cycles regular? Are you pregnant? If so, how many months?

14. Do you fatigue or tire easily? Does this fatigue increase during the performance of everyday activities or only with exercise? Do you feel fine in the morning and get progressively worse as the day goes on?

15. How many hours of sleep do you typically get each night?

16. Please describe your exercise habits

17. Do you experience or have difficulty with any of the following? If so, please indicate and explain.

Musculoskeletal
___Headaches
___Osteoporosis
___Tendonitis
___TMJ/jaw pain
___Labial/vaginal or scrotal pain
___Metallic taste in mouth
___Muscle cramping
___Difficulty swallowing
___Crackling in ears
___Accidental biting of inside of mouth

Psychological
___Depression
___Panic attacks
___Eating disorders
___Drug/alcohol addiction
___Other

Digestive
___Incontinence
___Diarrhea
___Constipation
___Intolerance of greasy food
___Reflux/heartburn
___Irritable bowel syndrome
___Ulcers

Skin and Connective Tissue
___Shingles
___Unexplained rashes
___Persistent fungus (i.e. ringworm or athlete's foot)
___Scleroderma
___Sarcoidosis
___Other

Cardio-respiratory
___Asthma
___Recurrent bronchitis
___COPD
___Arrhythmias
___Palpitations
___Chest pain
___Previous MI
___High or low blood pressure
___Congestive heart failure
___Leg swelling or lymphedema
___Phlebitis or blood clots

Medical
___Weight gain or loss
___Diabetes
___Cancer
___Autoimmune disorders
___Nervous system disorders
___Seizures
___Allergies

18. Do you feel you eat a balanced diet? Briefly describe a typical day's diet.

19. How much water (or other non-caffeinated fluids) do you drink in a day?

20. How many caffeinated drinks do you have in a day (coffee, tea, soda)?_____ In a week?_____

21. How many alcoholic drinks do you have in a day?_____ In a week?_____ If you gave it up, why?

22. How often do you use tobacco products (cigarettes, cigars, pipes, chewing tobacco)?

23. Please describe anything else you would like me to know prior to beginning treatment.