Arete Rehab, PLLC
DBA Arete Myofascial Release
PHYSICAL THERAPY INTAKE FORM

NAME:_____ **Date:**_____

Age:_____ **DOB:**_____ **Address:**_____

City:_____ **State:**_____ **Zip:**_____ **Telephone#:**_____

Occupation:_____

E-Mail Address:_____

Referring Physician:_____

Are you enrolled in Medicare? YES NO

On a scale of 0-10, with 0 = no pain/symptoms and 10 = pain/symptoms so intense you need to see a doctor. Please rate your pain or symptom intensity.

Now: ____/10

Best: (in the past week): _____/10

Worst: (in past week): _____/10

Please list medical history/operations/medications/past therapies:

_____

_____

_____

_____

_____

_____

Please state your goal in utilizing this specialized Therapy:_____

_____

1. What is the primary complaint that brings you here?

_____

2. Secondary complaint?_____

_____

3. Date symptoms began?_____

4. How did your symptoms begin?

_____
_____
_____

5. What activities aggravate your symptoms?_____

_____

6. What activities decrease your symptoms?_____

_____

*** Arete Rehab, PLLC DBA Arete Myofascial Release is an "out of Network" provider. Payment is due at time of service.**

*** I Give consent to treatment including the use of hands-on Myofascial Release and other interventions deemed beneficial by my therapist.**

Signature:_____ **Date:**_____

Please shade the areas on the body diagram where you have pain, symptoms, or restricted movement.