

**PHYSICAL THERAPY CENTER FOR CLINICAL EDUCATION AND HEALTH PROMOTION**

**INITIAL INTAKE/REFERRAL FORM**

**Client Information**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_

Home #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other #: ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_ □ Work □ Cell

D.O.B. \_\_\_\_\_\_\_\_\_\_ Marital Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Next of Kin Information**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home #: ( ) \_\_\_\_\_- \_\_\_\_\_\_\_\_ Other #: ( ) \_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_ □ Work □ Cell

Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Other Information**

Reason for Seeking Therapy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you received PT for this reason? □ Yes □ No

If Yes; when was the last time you have seen a PT? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about the Center? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If a therapist told you about the Center what is the therapist’s name? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Care Provider**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please send completed form to: Jane Baldwin

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 Charlestown Navy Yard

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 Fax: 617-643-0890

 jbaldwin@mghihp.edu or ptcenter@mghihp.edu