Marrone Sports Rehab

PRIVATE CONCIERGE PERFORMANCE PHYSICAL THERAPY

Patient Intake Questionnaire

Complete before your first visit — all fields required

1 Personal Information

FIRST NAME

LAST NAME

DATE OF BIRTH

MM / DD / YYYY

BIOLOGICAL SEX

HOME ADDRESS

Street, City, State, ZIP

CELL PHONE

( ) ___-____

EMAIL ADDRESS

EMERGENCY CONTACT NAME

EMERGENCY CONTACT PHONE

2 Insurance & Payment

Marrone Sports Rehab is a direct-pay, out-of-network practice. Payment is due at time of service. A superbill is available upon request for out-of-network (OON) reimbursement or HSA/FSA submission.

INSURANCE COMPANY (for superbill)

PLAN TYPE

PPO / EPO / HMO / Other

MEMBER ID

GROUP NUMBER

HSA / FSA CARD (Y / N)

PREFERRED PAYMENT METHOD

Credit / Check / Zelle

3 Chief Complaint & Current Condition

PRIMARY REASON FOR VISIT

Describe your main concern in your own words

PAIN LOCATION (be specific)

WHEN DID THIS BEGIN

MM / YYYY or approximate

HOW DID IT START?

- ☐ Gradual onset — no single event
- ☐ Acute injury during activity
- ☐ Gradual overuse
- ☐ Post-surgical
- ☐ Unknown / Other

PAIN TYPE (check all that apply)

- ☐ Sharp
- ☐ Dull / Aching
- ☐ Burning
- ☐ Throbbing
- ☐ Stiffness / Tightness
- ☐ Weakness
- ☐ Numbness / Tingling

PAIN NRS — AT REST (0–10)

0 = no pain, 10 = worst imaginable

PAIN NRS — WITH ACTIVITY (0–10)

WHAT MAKES IT WORSE?

Activities, positions, movements

WHAT MAKES IT BETTER?

Rest, ice, stretching, other

PRIOR TREATMENT FOR THIS ISSUE

PT / MD / Chiro / Injection / Surgery / None

OUTCOME OF PRIOR TREATMENT

4 Medical History

PRIOR INJURIES OR SURGERIES (include year)

List all — joint, spine, fracture, soft tissue, etc.

CURRENT MEDICATIONS (include supplements)

KNOWN ALLERGIES

Medications, latex, tape, other

CURRENT OR RECENT MEDICAL CONDITIONS (check all that apply)

- ☐ Cardiovascular disease
- ☐ Diabetes
- ☐ Rheumatoid / autoimmune arthritis
- ☐ Neurological condition
- ☐ Pregnancy
- ☐ Hypertension
- ☐ Osteoporosis / Low bone density
- ☐ Cancer (current or prior)
- ☐ Blood clotting disorder
- ☐ None of the above

PRIMARY CARE PHYSICIAN

REFERRING / ORDERING PHYSICIAN (if applicable)

5 Sport & Activity Profile

PRIMARY SPORT / ACTIVITY

POSITION / EVENT / DISTANCE

COMPETITION LEVEL

Youth / HS / College / Pro / Recreational

YEARS PARTICIPATING

SESSIONS PER WEEK

HOURS PER SESSION

UPCOMING EVENTS / COMPETITIONS / GOALS

Race date, season start, return-to-play target, etc.

6 Goals & Expectations

WHAT IS YOUR MOST IMPORTANT GOAL FOR PHYSICAL THERAPY?

HOW HAS THIS ISSUE IMPACTED YOUR DAILY LIFE OR SPORT?

HOW DID YOU HEAR ABOUT MARRONE SPORTS REHAB?

- ☐ Physician referral
- ☐ Google search
- ☐ Friend / family
- ☐ Golf club / facility
- ☐ Social media
- ☐ Other

By completing this form I confirm that the information provided is accurate and complete to the best of my knowledge.

SIGNATURES

Patient / Guardian Signature _____ Date _____

Printed Name _____ Date _____