INTAKE AND MEDICAL HISTORY FORM

Patient Name:_____ AGE_____ GENDER: M F

What body part(s) is/are you being treated for today?_____

_____

Describe the type and location of your symptoms?_____

_____

Please estimate the date that your present symptoms began? _____

Please describe how your symptoms began (examples: injury, car accident, fall, work, gradual increase, not sure, etc)? _____

_____

Did you have surgery? YES NO If yes, when? _____

Please describe your current symptoms: Getting Better Getting Worse Staying The Same

Have you received any previous treatment for this current problem? (If yes, please circle or add a description):
Injections Chiropractic Physical/Occupational Therapy Pain Management

Other:_____

If you have received previous PT/OT therapy in this calendar year, approximately how many sessions have you attended? _____ How did you do? Better Same Worse

What makes your symptoms worsen? _____

What activities are currently limited due to your current problem(s)?_____

_____

Please list your goals for therapy?_____

MEDICAL HISTORY

Have you recently noticed any of the following symptoms (please circle)?

Dizziness Headaches Shortness of Breath Nausea/Vomiting Pain at night

Changes in appetite Fever/Sweats/Chills Difficulty swallowing Changes in bowel/bladder function

Difficulty Keeping Balance Weakness/Fatigue

Please list if you have any allergies (such as to latex or adhesives):_____

Please list any significant past medical history and the dates (examples can include any surgeries, falls, pacemaker, fractures, etc): _____

Have you ever been diagnosed with any of the following conditions? (please circle)

Heart Attack Stroke/CVA Cancer Diabetes RA Osteoporosis HIV Positive Hepatitis

Are you pregnant? YES NO If Yes, how many weeks? _____

MEDICATIONS

Please provide a detailed list of all medications, over-the-counter drugs, vitamins, or supplements that you are currently taking. (You can avoid this section only if you provided a detailed list that we copied into your medical record)—Please use back of sheet as needed

MEDICATION NAME	DOSAGE AMOUNT	FREQUENCY TAKEN
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list any medication you are allergic to:_____

SOCIAL HISTORY

How many times a week do you exercise/perform hobbies? _____

Please Describe these activities:_____

Do you use tobacco? Yes No If Yes, how often, amount, and type?_____

Do you drink alcohol? Yes No If yes, how often, amount, and type?_____

Where do you currently live? Ranch house Multiple level House Nursing Home

Do you have to use stairs? Yes No If yes, how many stairs? _____

If yes, where are railings as you go up the stairs? (circle all that apply)

Right Only Left Only On Both Sides No Railings

Do you live alone? Yes No

Are you currently working? No Full Duty Light Duty Off work

If not working, what was the last day you worked?_____

Is there any other information you think we should know that has to do with you treatment?

_____

The signature below verifies that the information listed above is complete, accurate, and true to the best of your knowledge.

_____ _____

PATIENT/GUARDIAN SIGNATURE DATE