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PATIENT HEALTH INTAKE FORM

Please share with me your health information that may influence your physical therapy progress.

NAME: _____ DATE: _____

DATE OF BIRTH: _____ AGE: _____

ADDRESS: _____

GENDER IDENTITY: _____ PREFERRED PRONOUNS: _____

PREFERRED/PRIMARY LANGUAGE: _____

PLACE OF EMPLOYMENT: _____

MARITAL STATUS: _____

NAME & SPECIALTY OF HEALTH CARE PROFESSIONAL WHO REFERRED YOU TO PHYSICAL THERAPY:

NAME(S) OF ANY OTHER PROFESSIONAL(S) INVOLVED IN YOUR PHYSICAL THERAPY CARE:

DO YOU HAVE AN ORDER/SCRIPT/REFERRAL FOR PHYSICAL THERAPY FROM A LICENSED PHYSICIAN,
DENTIST, PODIATRIST, NURSE PRACTITIONER, OR LICENSED MIDWIFE? **Y N**

HAVE YOU INDICATED THE BEST WAY TO CONTACT YOU ON THE HIPAA PRIVACY NOTICE? **Y N**

HAVE YOU INDICATED AN EMERGENCY CONTACT ON THE HIPAA PRIVACY NOTICE? **Y N**

HAVE YOU SIGNED THE INFORMED CONSENT FORM? **Y N**

HAVE YOU DISCUSSED ADVANCE DIRECTIVES WITH YOUR PCP? **Y N**

CURRENT MEDICAL HEALTH HISTORY**PLEASE CHECK ALL THAT APPLY:**

- ☐ Heart Condition
- ☐ Cardiovascular Disease
- ☐ High Blood Pressure
- ☐ Heart Attack
- ☐ Heart Surgery
- ☐ Pacemaker/Defibrillator
- ☐ Blood Disease
- ☐ Anemia
- ☐ Diabetes
- ☐ Hypoglycemia
- ☐ Blood clots
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Urinary Incontinence
- ☐ Osteoporosis
- ☐ Osteopenia
- ☐ Bone fracture
- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis
- ☐ Musculoskeletal Issues
- ☐ Fibromyalgia
- ☐ Chronic Fatigue/ME
- ☐ Lupus
- ☐ Parkinsons
- ☐ Multiple Sclerosis
- ☐ Cerebral Palsy
- ☐ Developmental Delay
- ☐ Traumatic Brain Injury
- ☐ Paralysis
- ☐ Muscular Dystrophy
- ☐ Polio
- ☐ Seizure activity
- ☐ Respiratory Issues
- ☐ Cystic Fibrosis
- ☐ Asthma
- ☐ COPD
- ☐ Shortness of Breath

- ☐ Neurological Disorder
- ☐ History of Stroke
- ☐ TIA
- ☐ Cancer
- ☐ Thyroid problems
- ☐ Stomach Problems
- ☐ Bowel Issues
- ☐ Reproductive system issues
- ☐ Chronic pain
- ☐ Altered sensation in hands/feet
- ☐ Skin wounds
- ☐ Tuberculosis
- ☐ Hepatitis
- ☐ Long COVID
- ☐ Allergies
- ☐ Food Intolerances
- ☐ Balance and Coordination issues
- ☐ Difficulty swallowing
- ☐ Major Surgery
- ☐ Depression
- ☐ Anxiety
- ☐ Other mental health conditions

In the past year have you experienced any of the following?

- ☐ Chest discomfort with exertion
- ☐ Unexpected shortness of breath
- ☐ Dizziness, fainting, or blackouts
- ☐ Ankle/foot or hand swelling
- ☐ Irregular, rapid, or excessively strong heart beat
- ☐ Burning or cramping sensation in lower legs with short distance walks

Are there any other health conditions, diseases, injuries, or surgeries you have had that were not previously mentioned?

CURRENT MEDICAL HEALTH HISTORY CONTINUED

Imaging or lab tests done for the condition that brought you to physical therapy:

Medications (prescription and over the counter): _____

Supplements/Herbs/Homeopathy/Naturopathic remedies/TCM remedies: _____

Please list any and all allergies including medications, supplements, foods, and environmental: _____

Do you use tobacco or nicotine products? If yes, what and how much?

Do you drink alcohol? If yes, what and how much?

Do you use recreational drugs? If yes, what and how much?

Do you follow a particular nutritional diet? If yes, what?

How well are you sleeping at night?

How often do you get outside for recreation or exercise?

What types of physical activity do you engage in regularly?

Have you fallen in the past year? If yes, what happened?

Do you currently feel unsteady when standing/walking and worry about falling? Y N

Is there anything more about your health you would like me to know?

What are your goals for physical therapy? _____
