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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:

_____

_____

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
- ○ High Cholesterol
- ○ 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? _____

_____

_____

_____