Medical Intake Form

Please select each of the topics that relate to your medical history:

- ☐ Anemia
- ☐ Back Pain
- ☐ Bronchitis
- ☐ Drink alcohol
- ☐ Gout
- ☐ Hernia
- ☐ Parkinson's
- ☐ Severe/frequent headache
- ☐ Stroke/TIA
- ☐ Vision difficulties
- ☐ Women's health issues
- ☐ A pacemaker
- ☐ Angina
- ☐ Blood Clot/Emboli
- ☐ Coronary Heart Disease
- ☐ Emphysema
- ☐ Hearing Difficulties
- ☐ High Blood Pressure
- ☐ Pneumonia
- ☐ Sleeping Problems
- ☐ Thyroid Problems
- ☐ Weakness
- ☐ Allergies
- ☐ Asthma
- ☐ Bowel/Bladder problems
- ☐ Dizziness/Faintness
- ☐ Epilepsy/Seizures
- ☐ Heart Attack
- ☐ Kidney Disease
- ☐ Pregnant
- ☐ Smoke Cigarettes
- ☐ Varicose Veins
- ☐ Weight Loss/Energy Loss

Please select body area that is involved with your medical history:

☐ Ankles	☐ Right	☐ Left	☐ Both
☐ Elbows	☐ Right	☐ Left	☐ Both
☐ Hips	☐ Right	☐ Left	☐ Both
☐ Knees	☐ Right	☐ Left	☐ Both
☐ Legs	☐ Right	☐ Left	☐ Both
☐ Shoulders	☐ Right	☐ Left	☐ Both
☐ Wrists	☐ Right	☐ Left	☐ Both

Please select any of the following relate to your medical history:

☐ Numbness/Tingling/Neuropathy	Right/Left	Body Area:______________________
☐ Arthritis	Right/Left	Body Area:______________________
☐ Joint Replacement	Right/Left	Body Area:______________________
☐ Pins/Metal Implant	Right/Left	Body Area:______________________

Please select any of the following that relate to your medical history:

- ☐ Cancer
- ☐ Diabetes, Type 1
- ☐ Caregiver for someone
- ☐ I live alone
- ☐ I use a walker
- ☐ Incontinence
- ☐ My home has stairs
- ☐ Other surgery
- ☐ Vertigo/Balance
- ☐ CRPS
- ☐ Diabetes, Type II
- ☐ Received Home Physical

Therapy

- ☐ I use a cane
- ☐ I use a wheelchair
- ☐ Infectious Disease
- ☐ Other Important Issues
- ☐ Pelvic Floor difficulties

How often do you Exericse:

- ☐ Never
- ☐ Usually once per week
- ☐ Usually two times per week
- ☐ Usually 3 times per week
- ☐ 4 or more times per week

Does your daily routine, or work, aggravate your injury?

- ☐ No
- ☐ I am unable to participate in my normal routines or work
- ☐ My routine/work usually impacts my injury 1 day per week
- ☐ My routine/work usually impacts my injury 2 day per week
- ☐ My routine/work usually impacts my injury 3 day per week
- ☐ My routine/work impacts my injury every day, but I try to cope

Please list all the medications you are currently taking:

If you have a prepared list of medications, please give to the front desk and skip to the next section

________________	________________	________________
________________	________________	________________
________________	________________	________________
________________	________________	________________

Please place an 'X' or circle the body part(s) that prompted today's visit:

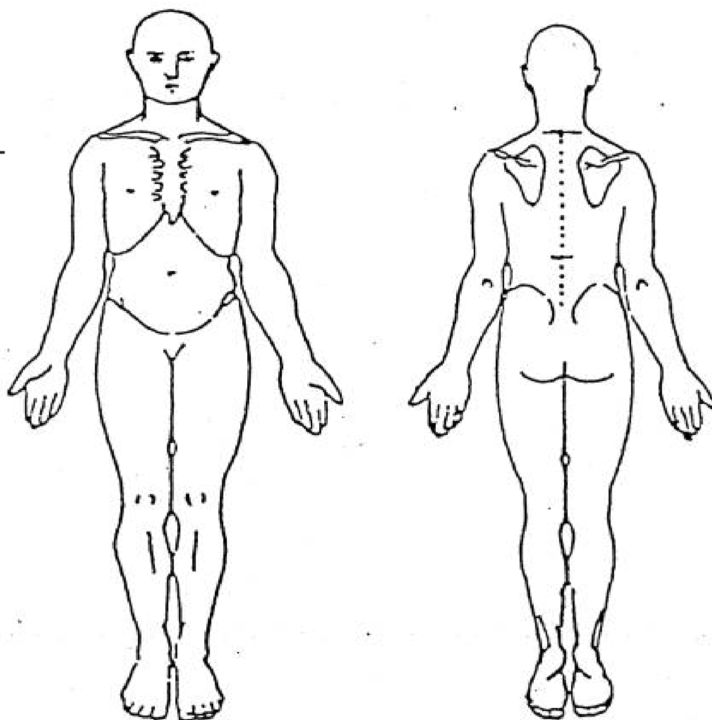
Other Reasons for Visit:

- ☐ Incontinence
- ☐ Vertigo
- ☐ Complex Regional Pain Syndrome
- ☐ Pelvic Floor

Is this a recurrence of a prior injury?

- ☐ Yes
- ☐ No

If Yes, what year did it occur? ________________



Please choose what describes your pain (select all that apply):

- ☐ Aching
- ☐ Burning
- ☐ Constant
- ☐ Cramping
- ☐ Deep
- ☐ Dull
- ☐ Heavy
- ☐ Numb
- ☐ Pins and Needles
- ☐ Stabbing
- ☐ Throbbing
- ☐ Variable
- ☐ Weak

Please rate the pain (0 = no pain, 10 = worst pain I've ever felt):

Current:	0	1	2	3	4	5	6	7	8	9	10
At Best:	0	1	2	3	4	5	6	7	8	9	10
At Worst:	0	1	2	3	4	5	6	7	8	9	10

What makes your pain **worse**? (check all that apply):

- ☐ Reaching back
- ☐ Lying flat
- ☐ Getting up out of bed
- ☐ Dressing and grooming
- ☐ Cooking
- ☐ Carrying items
- ☐ Climbing stairs
- ☐ Lifting anything
- ☐ Lifting heavy weights
- ☐ Pulling
- ☐ Raising arm over the head
- ☐ Looking up/down
- ☐ Walking

What **relieves** your pain? (check all that apply):

- ☐ Ice
- ☐ Heat
- ☐ Stretching
- ☐ Exercise
- ☐ Pain medication
- ☐ Lying flat
- ☐ Avoiding activity
- ☐ Nothing

How many times have you fallen in the past year?

- ☐ 0 times
- ☐ 1 times
- ☐ 2 times
- ☐ 3 times
- ☐ 4 times
- ☐ 5 times
- ☐ 6 or more times

Were you injured? Yes / No

Name: ______________________________ Date of Birth: ___ /___ /______

Height: ____ ft ____ in Weight: ______ lbs