

Patient's Medical History Intake Form

Personal Information

Name _____ Sex M F DOB ___/___/___ Date ___/___/___
Marital status: Single Married Widowed Divorced Do you live alone? Yes No
Do you take care of someone else? Yes No If yes what are the ages? _____
Occupation _____ Are you currently employed? Yes No

Work Status: Full time Part time Retired Off because of the current problem How long? _____
Type of work: Office Physical Do expect to fully return to work? Yes No
Leisure Activities/Hobbies _____

Do you exercise regularly? Yes No If yes, how many times per week? _____
Do you currently smoke? Yes No If yes, how many packs a day? _____ For how many years _____
If no, were you a former smoker? Yes No When did you quit? _____
Do you drink alcohol? Yes No Amount _____ drinks per Day Week Month

Would you describe your sleep as Good Fair Poor
Do you wake up at night because of the current problem? Yes No If Yes, how many times? _____
Is your mattress Firm Medium Soft? How old is your mattress? _____
Do you currently take medications to sleep? Yes No If yes, Is it Pain Muscle relaxant
 Other _____

Home Environment

Do you currently use Walker Rolling walker Cane Crutches Brace Splint for walking/moving
Do you live in An Apartment A Single story home 2-Story home
Do you live Alone With spouse With my child/children
 With my parents With a friend With significant other _____
Do you have Stairs in the house Stairs to go in the house No stairs
Where is your bedroom located? In first floor In second floor In basement Other _____
Shower/bathing is located in: First floor Second floor Basement
Laundry is located in: First floor Second floor Basement
Toilet is accessible in First floor Second floor Basement
Do you have steps to enter house? Yes No If yes how many? _____
Do you have side rails? Yes No If yes is it on: house? Yes No If yes how many _____
Do you have side rails? Yes Right Left Both sides No side rails
During the past month have you been feeling down, depressed, or hopeless? Yes No
During the past month have you been bothered by having little interest or pleasure in doing things?
 Yes No
Is this something with which you would like help? Yes Yes, but not today No

PAST MEDICAL HISTORY AND SCREENING

Have you recently experienced any of the following?

- | | | |
|---|---|--|
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Falls | <input type="checkbox"/> Cough |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Dizziness/light headedness | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Nausea/vomiting |
| <input type="checkbox"/> Fever/chills/sweats | <input type="checkbox"/> Heartburn/indigestion | <input type="checkbox"/> Muscle weakness |
| <input type="checkbox"/> Balance problem while walking | <input type="checkbox"/> Constipation | <input type="checkbox"/> Numbness/tingling |
| <input type="checkbox"/> Changes in bowel or bladder function | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Weight loss/gain |

Have you ever been diagnosed with the following?

- | | | |
|--|--|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Neuropathies |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Chest Pain/Angina | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Skin Rashes | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Autoimmune Disease |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Peripheral Vascular Disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Bladder Infection | <input type="checkbox"/> Allergies to food or medicine |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Urinary Tract Infection | <input type="checkbox"/> Stomach/Intestinal Problems |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Liver Problems | <input type="checkbox"/> Lung/Breathing Problems |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Kidney/Renal Problems |

Has anyone of your family ever been diagnosed with any of the following conditions:?

- | | | |
|--|-------------------------------------|---|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Heart problems | <input type="checkbox"/> Stroke | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Depression | <input type="checkbox"/> Blood clots |

Nutritional History

How are your eating habits? Good Fair Poor

Has there been any change in your appetite in the past six months Yes No

Have you gained or lost weight (more than 10 pounds) in one month without wanting to? Yes

No If yes, how much weight gained or lost? _____

Are you happy with your weight? Yes No If No, are you on a diet and exercise program?

Past Surgical History: Please list your previous surgeries and the year you had the surgery.

Past Surgical History			
Please list your previous surgeries, and the year you had the surgery			
Surgery	Hospital	Year	
Current Medications			
Please list all medications you are currently taking, including those you buy without a doctor's prescription (such as Aspirin, supplements, and herbs). If you have a list of medications you may give us a copy and skip this section			
Prescriptions	Prescriptions	Over-the-Counter	Herbs / Vitamins
Have you taken steroid medications for any condition? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Prescribed Blood thinners/anti-coagulants? <input type="checkbox"/> Yes <input type="checkbox"/> No			

History of Present Illness

What is the reason for you visit today?

What do you think caused your symptoms?

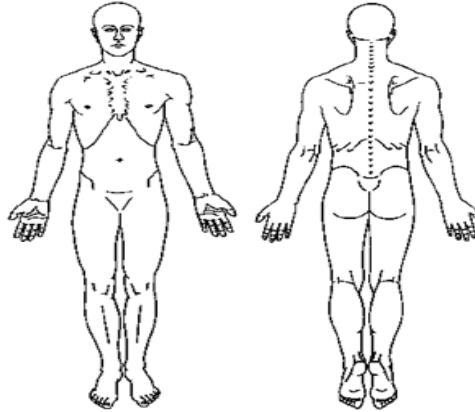
Are the symptoms currently: Getting better Getting worse Staying about the same
Have you ever had this problem before? Yes No If yes, When

Did you receive treatment for this problem before? Yes No
How long did it take for you to feel better?

Body Chart

Please mark the areas where you feel symptoms on the chart with the following symbols to describe your symptoms:

- Shooting / sharp pain
- Dull / aching pain
- Numbness
- Tingling



Pain Assessment:

Do you have pain now? Yes NO If yes, when did it start? _____

If no you can skip the section below

Pain intensity 0 = no pain and 10 = worse pain requiring emergency room visit

Rate pain right now _____ Average in the past 24 hours _____ Best in the past 24 hours _____ worst in the past 24 hours

Is your current pain: constant Intermittent

Name three activities or positions that make your pain worse: 1- _____ 2- _____ 3- _____

Name three activities or positions that relieve your pain: 1- _____ 2- _____ 3- _____

What time of the day is your pain worst? Morning Mid-day Evening Night

If mornings, do you feel Stiff Sore

Prior Treatment:

Have you previously received: Physical therapy Occupational therapy Chiropractic Injections
Therapist

Therapist Signature: _____ Date: ___/___/___ Patient Signature: _____ Date: ___/___/___