Medical History Intake

Name _____ Maiden Name/AKA_____

Referring MD and Office Location _____

Emergency Contact: Name _____ Phone (____) _____-_____

What kinds of activities (exercise/hobbies) do you enjoy? _____

Have these changed since your illness/injury? Yes No If Yes, how so? _____

Date of Injury Onset _____ Date of Surgery_____

If this was an injury, how did it occur?_____

Have you had any Physical Therapy since January 1st? Yes No If Yes, how many visits?_____

Have you had any diagnostic testing forth this illness/injury? Yes No

If so, what type? (X-ray, MRI, etc)_____

Have you received any other rehabilitative services for this condition? Yes No

If so, what type? (PT, OT, Chiropractic, etc)_____

Are you currently taking any medications for your illness/injury? Yes No

If so, please list: _____

_____

Rate your pain on a scale of 1-10 (0 for no pain, 10 for worst pain) 1 2 3 4 5 6 7 8 9 10

Do you have any pins or metal implants? Yes No Do you have a pacemaker? Yes No

Are you Pregnant? Yes No

Do you smoke? Yes No If so, how often? _____

Do you drink alcohol? Yes No If so, how often? _____

Are you scheduled for any upcoming surgical procedures? Yes No If yes, please describe _____

Please check off any and all condition(s) that you have, or have had in the past:

__ Emotional/Psychological Problems
_ _Coronary Heart Disease/Angina
__ Severe or frequent headaches
__ Asthma/Bronchitis
__ Shortness of breath
__ Stroke/TIA
__ Thyroid/Goiter
__ Motor Vehicle Accident
__ Frequent UTI's
__ Hernia
__ Blood Clot/Emboli
__ Heart Attack/Surgery
__ Emphysema
__ Weight Loss/Gain
__ Varicose veins
__ Anemia
__ Diabetes
__ Lyme Disease
__ High blood pressure
__ Dizziness or faintness
__ Vision difficulties
__ Sleeping difficulties
__ Hearing difficulties
__ Epilepsy/Seizures
__ Energy loss
__ Gout
__ Latex/Adhesive Allergy

If any of the following are checked off, please provide more information:

__ Numbness or tingling _____
__ Muscle weakness_____
Osteoporosis_____
__ Shoulder injury/surgery_____
__ Back injury? Surgery_____
_____
__ Bowel /Bladder problems_____
__ Arthritis/Swollen joints_____
__Cancer_____
__ Joint replacement_____
__ Elbow injury/surgery_____
_____
__Knee injury/surgery_____
_____
__ Leg/Ankle/Foot injury/surgery___
_____
__ Infectious disease_____
__Allergies_____

Are there any other conditions or issues to note that would help us treat you?_____

I authorize you to speak with the following person (people) regarding my condition or appointments:

Name_____ Relationship_____

Name_____ Relationship_____

I hereby agree and give my consent to medical treatment regarding my physical condition. I authorize the release of any medical information needed to process my claim. I understand I am responsible for any charges that are not covered by my insurance. Furthermore, I understand I am responsible to inform the office of any changes that occur.

Patient/Parent/Guardian Signature _____ Date: _____

Please initial to acknowledge that you have received and read the Notice of Privacy Practices _____