Medical Intake Form

Patient Label

Name:_____
Occupation:_____
Do you have a pacemaker? Yes No
Do you smoke? Yes No How many packs per day?_____
For Women: Are you currently pregnant? Yes No Maybe If yes, Due Date_____
Allergies: Are you allergic to any medications? Yes No If yes, please list_____
Are you allergic to latex? Yes No

Have you **recently** noted any of the following symptoms?

◯ Fatigue	◯ Dizziness	◯ Heart palpitations
◯ Fever/chills/sweats	◯ Double Vision	◯ Chest pain
◯ Nausea/vomiting	◯ Difficulty swallowing	◯ Depression
◯ Weight loss/gain	◯ Difficulty speaking	◯ Changes in Bowel or bladder function
◯ Balance problems	◯ Fainting episodes	◯ Changes in appetite
◯ Weakness	◯ Difficulty walking	◯ Headaches
◯ Numbness/tingling	◯ Shortness of Breath	◯ Increased pain at night
◯ Abdominal pain	◯ Increased swelling in hands/legs	◯ Heart burn/Indigestion
◯ Persistent cough	◯ Hearing changes	◯ Falls

Have you **ever** been diagnosed with any of the following conditions (check all that apply)?

◯ Cancer..What kind_____	◯ Infectious Disease (ie. TB/Hepatitis)	◯ Osteoporosis
◯ Heart Disease..What kind_____	◯ Sexually transmitted disease/HIV	◯ Osteoarthritis
◯ High Blood Pressure	◯ Pelvic inflammatory disease	◯ Rheumatoid arthritis
◯ Chest pain/angina	◯ Asthma/Lung/Breathing problems	◯ Kidney problem/infection
◯ High Cholesterol	◯ Stroke/CVA	◯ Thyroid problem
◯ Diabetes **If checked: Insulin Yes/No**	◯ Hearing Problems	◯ Multiple Sclerosis
◯ Hypoglycemia	◯ Eye problem/infection	◯ Ulcers
◯ Depression	◯ Seizures/Epilepsy	◯ Liver problems
◯ Pneumonia	◯ Anemia	◯ Stomach problems
◯ Circulatory or Vascular problems	◯ Bone or joint infection	◯ Gallbladder problems
◯ Blood clots	◯ Chemical dependency (ie. Alcoholism, drugs)	◯ Prostate problem (**men**)
◯ Dental Problems		

During the past month, have you been feeling down, depressed or hopeless? **YES or NO**
During the past month, have you been bothered by having little interest or pleasure in doing things? **YES or NO**
Is this something with which you would like help? **YES** **YES, BUT NOT TODAY** **NO**

Please list your current prescription and non-prescription medications and state the condition for which you are taking each medication:

1._____ Reason:_____ 4._____ Reason:_____
2._____ Reason:_____ 5._____ Reason:_____
3._____ Reason:_____ 6._____ Reason:_____

Please list any surgeries or hospitalizations you have had, including dates:

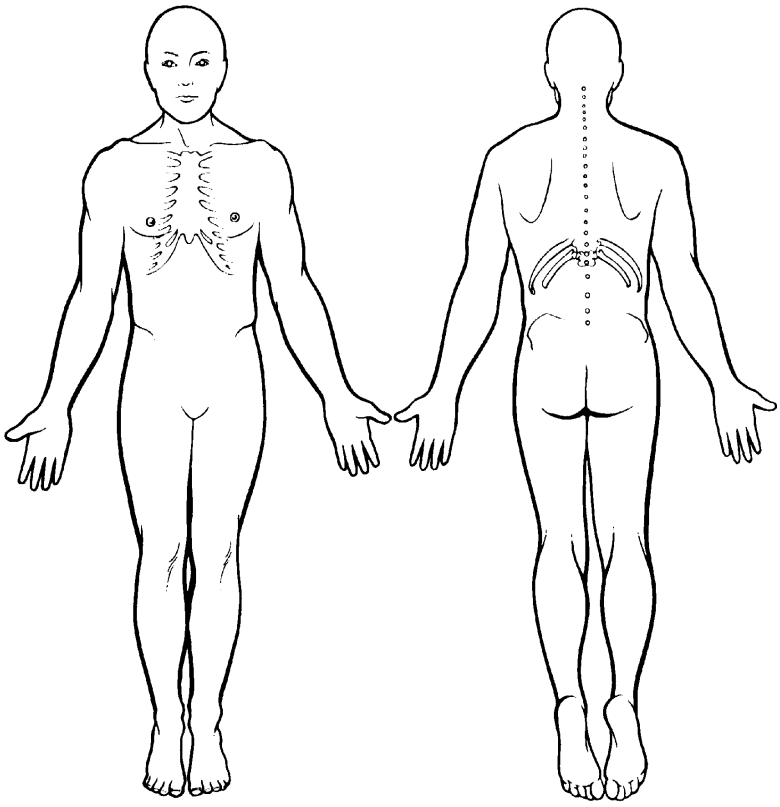
_____
_____

See Back ►

Medical Intake Form

Body Chart: Please mark the areas where you feel pain on the chart to the right with the following symbols to describe your pain:

↓ shooting/sharp pain
O Dull/aching pain
III Numbness
= Tingling



For the therapist use

+ / - Cough/Sneeze
+ / - Saddle Anesth.
+ / - Bwl/Blddr Chnge
+ / - Numb/Ting.
+/- Dizziness
+/- Diplopia
+/- Dysarthria
+/- Dysphagia
+/- Drop attacks

Scale 0-10, with 0 being "no pain" and 10 being the "worst pain imaginable"

Please rate your pain: **Current**: __/10; **@best**: __/10; **@worst**: __/10.

My symptoms: ◯ Come & go ◯ Are constant ◯ Are constant, but change with activity
My symptoms are: ◯ Getting better ◯ Getting worse ◯ Staying about the same

Date of last doctor visit for **this** problem:_____
Date of next doctor visit for **this** problem:_____

What is your expectation/goal for attending therapy?_____

Is there anything else you would like the therapist to know about your health or current problem that has not been asked on this questionnaire? YES or NO. If yes, please state:

_____
_____
_____
_____

Patient/Guardian Signature_____ Date:_____