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?

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

Have you ever been diagnosed with the following?

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

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

□ Cancer □ Diabetes □Tuberculosis
□ Heart problems □Stroke □Thyroid problems
□High blood pressure □Depression □ 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
o

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? □
s □ No

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? ☐ Yes ☐ No
Prescribed Blood thinners/anti-coagulants? ☐Yes ☐ 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

_____

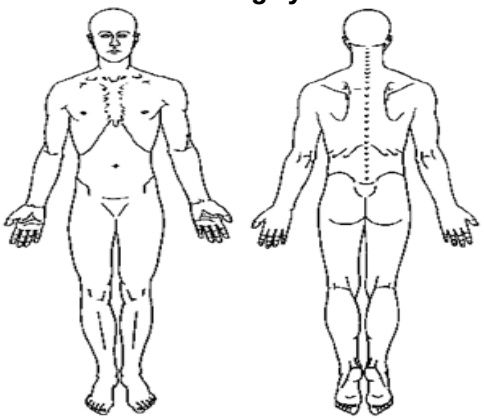
Did you receive treatment for this problem before? □Yes □No
How long did it take for you to feel better?

_____

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
III Numbness
= Tingling



Pain Assessment:

Do you have pain now? □Yes □NO If yes, when did it rt?_____
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:___/___/___