Outpatient Therapy – Medical History Intake Form

Date:_____ Time: _____

Name: _____ Occupation: _____

Personal Medical History:

Has a health professional ever diagnosed you with any of the following? Please X all that apply:

Cardiac
__ Congenital heart defect
__ Congestive heart failure
__ Atrial fibrillation
__ High blood pressure
__ Low blood pressure
__ Circulation problems
__ History of blood clots
__ Pulmonary embolism
__ Pacemaker
__ Anemia
__ Chest pain/angina
__ Arrhythmia/palpitations

Lung Disease
__ Coughing/wheezing on exertion
__ Asthma
__ Emphysema
__ COPD
__ Tuberculosis
__ Sleep Apnea

Joint/Muscle
__ Fibromyalgia
__ Joint, tendon, or muscular pain
__ Rheumatoid arthritis
__ Osteoarthritis
__ Regional pain syndrome/CRPS
__Osteopenia
__Osteoporosis

Gastrointestinal
__ Abdominal pain
__ Colitis
__ Diverticulitis
__ Ulcers
__ Irritable bowel syndrome
__ Chron's Disease
__ Reflux

Neurological
__ Epilepsy/seizure disorder
__ Stroke/CVA/TIA
__ Multiple sclerosis
__ Parkinson's
__ Dizziness
__ Vertigo
__ History of fainting

Psychological
__ Depression
__ Anxiety
__ Bipolar

General
__ Diabetes
__ Cancer
__ Thyroid problems
__ HIV/ AIDS
__ Neuropathy
__ Severe Headaches
__ Gout
__ Skin problems
__ Chemical dependency (alcoholism, etc.)
__ High cholesterol
__ Prostate problems
__ Lyme disease
__ Liver disease
__ Kidney disease
__ Hepatitis A, B, C
__ Lupus

Other:_____

Any comments or additions to any of the above: _____

_____

Have you fallen in the last year? Yes No Number of falls in the last year? _____

Describe: _____

Have you **recently** noted:
__ **Unexplained** weight loss/gain
__ Fatigue
__ Headaches
__ Difficulty swallowing
__ Nausea/vomiting
__ Dizziness
__ Fever/chills/sweats
__ Change in appetite
__ Numbness/tingling
__ Shortness of breath
__ Pain at night
__ Change of interest

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Are you pregnant? Yes No
How much do you smoke a day? _____How many alcoholic beverages do you consume weekly? _____

Surgical History
Please list any surgeries or other conditions for which you have been hospitalized, within the last 10-15 years, including the approximate date and reason for surgery or hospitalization:

Date	Reason for surgery/hospitalization

Please describe any **significant injuries** for which you have been treated in the last 10 years, (including fractures, dislocations, sprains) and the approximate date of injury:

Date	Injury	Date	Injury

Allergies
Any medication(s) you are allergic to: _____
Any other allergies: _____
Adhesive tape allergy: YES NO Latex allergy: YES NO

Medications
May provide a separate copy of medication list or please list any prescription and over the counter medication(s) you are currently taking (including pills, injections, and/or skin patches):
1._____ 5._____ 9._____
2._____ 6._____ 10._____
3._____ 7._____ 11. _____
4._____ 8._____ 12._____

Current Injury:

Onset due to: __ Sports __ Recreational __ Trauma __ Work related __ Injury at home __ Unknown
__ Sudden __ Slow onset __ Chronic (more than 2 months)
Other: _____

Describe your symptom trend (check all that apply): __ Improving __ Unchanging __ Worsening
Frequency of your pain: __ Constant __ Intermittent (daily) __ Occasional (less than daily)
__ Sporadic (less than weekly) Specifically _____

Pain intensity

0 = no pain 10 = pain so intense you need to go the hospital, worst imaginable

Please provide pain intensity number for the following: At worst (highest): ___ At best: ___

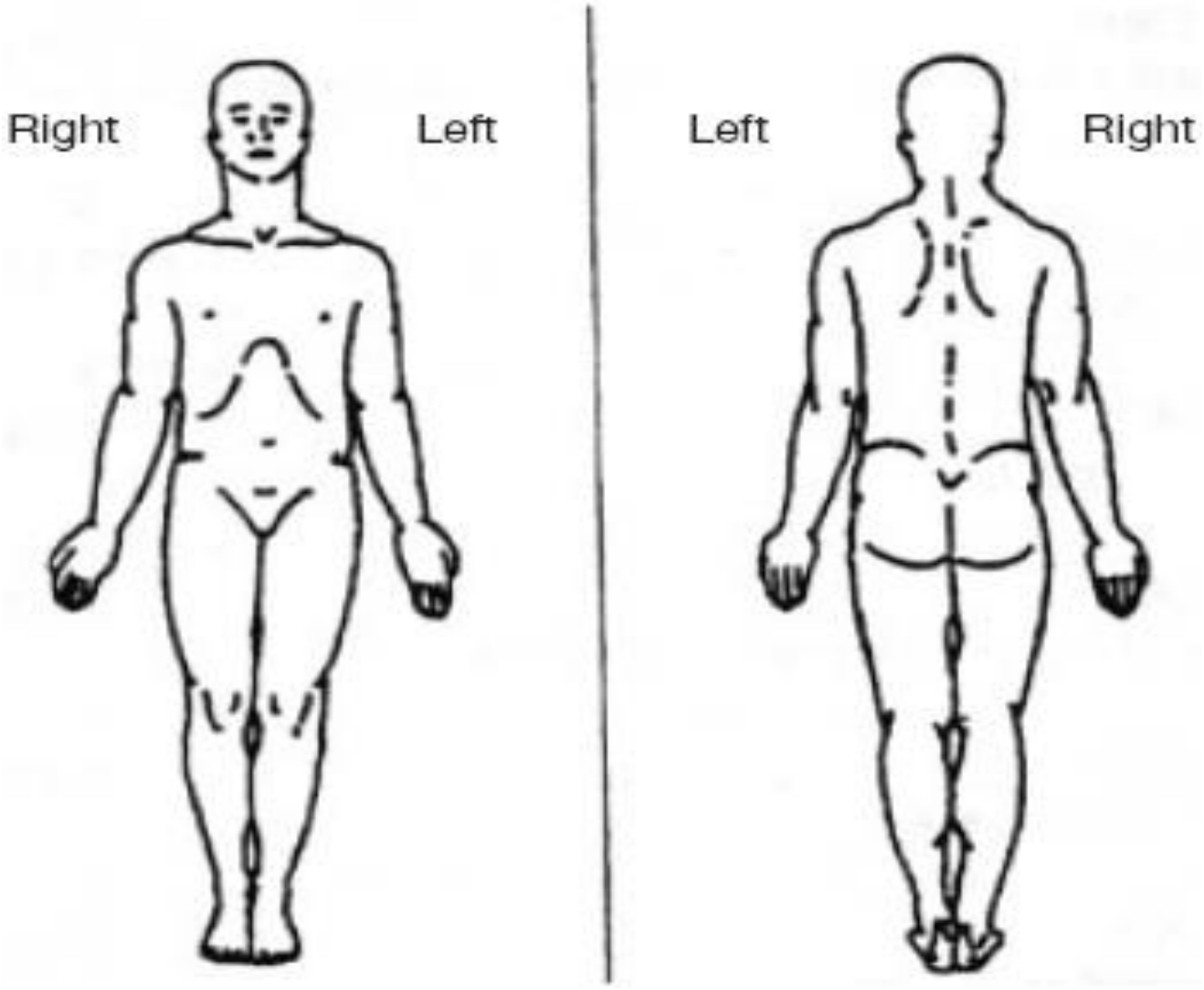
Pain worse at (check all that apply): ___Morning ___Day ___ Night

At rest: ___ With movement: ___ Is the pain worse with coughing or sneezing? YES NO

Specify movements: _____

Please indicate where your pain/symptoms are by marking X at the location and check how your pain feels:

__ Ache __ Burning __ Numbness __ Pins and needles __ Stabbing Other: _____



What is your **goal** for therapy? _____

Patient signature: _____ **Date:** _____ **Time:** _____

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