Therapy Medical History Intake Questionnaire

Name: _____Date:_____ Height: _____ Weight: _____
DOB: _____ Referring Physician: _____ Primary Physician: _____
Diagnosis: _____
Have you received PT, OT, or Speech Therapy since January 1st of this year? □ Yes □ No Where? _____
Are you currently being seen by Home Health? □ Yes □ No If yes, which one? _____

Mechanism of injury

When/How did your problem start & was it due to a specific injury? _____
_____
_____

- Please check (☑) all previous treatments you have had for this condition

□ Physical Therapy □ Chiropractor □ Medications Other:_____

Surgeries

- Please check (☑) any surgeries you have had:

□ Abdominal □ Back/Neck □ Joint □Other: _____

Medical Conditions

- Please check (☑) any condition for which you have been treated for, currently or in the past:

□ Arthritis (OA/RA)
□ Cancer/Leukemia
□ Cardiac/Heart Problems
□ Circulatory Problems
□ Diabetes (high sugar)
□ DVT (blood clots)
□ Gout
□ Head Injury/Concussion
□ Hypertension (high blood pressure)
□ Infectious Diseases
□ Kidney Problems
□ Liver Problems
□ Lung Problems
□ Osteoporosis/Osteopenia
□ Pacemaker
□ Seizures
□ Stroke/TIA
□ Thyroid Problems
□ Balance Problems/Frequent Falls
If yes to frequent falls, is MD aware? _____
□ Are you Pregnant?
□ _____

Review of systems

- Please check (☑) any of the following which you are **currently** experiencing:

□ Abdominal Pain/Bloating
□ Bladder/Bowel Problems
□ Chest Pain
□ Depression
□ Difficulty Swallowing
□ Do you smoke? _____
□ Fainting
□ Fatigue
□ Fever
□ Headaches
□ Heartburn
□ Irregular or Missed Periods
□ Joint Stiffness/swelling
□ Lack of Appetite
□ Nausea/Vomiting
□ Night Pain
□ Night Sweats
□ Numbness/Tingling
□ Pain Radiating Down Arm(s)/Leg(s)
□ Persistent Cough
□ Ringing/Buzzing in Ears
□ Shortness of Breath
□ Sore throat
□ Unexplained Weight Loss/Gain
□ Visual Changes
□ Weakness

List any other medical problems that have not already been listed: _____

Allergies:

- Please check (☑) any of the following items which you are allergic to:

□Bees □ Latex/Tape □Nuts □ Other:_____

What are you learning preferences? □ Discuss it with me □ Demonstrate it to me □ Teach my caregiver
□ Watch a video (if available) □ Give me a written handout

Patient goal: _____

Any other concerns you have that we should be aware of? _____
_____

By signing below, I attest that I have personally reviewed the information on this sheet.

Patient signature: _____ Date: _____