PATIENT HISTORY / INTAKE FORM

Print Form

Today's Date: | Referral Source:

PATIENT INFO: Name: | Gender: ☐ Male ☐ Female | Hand Dominance: ☐ R ☐ L

Date of Birth: | Occupation: | Education: ☐ High School ☐ Some College ☐ College Graduate

SOCIAL HISTORY

Do you have any customs or beliefs that might affect Care?

Do you live with: ☐ Alone ☐ Spouse ☐ Children ☐ Other

Do you exercise beyond normal activities and chores? ☐ Y ☐ N

If yes, how many times per week? | How many minutes?

What type of exercise?

HEALTH HABITS

General Health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you have an Advanced Directive (Living Will)? ☐ Y ☐ N ☐ Unsure

Do you smoke? ☐ Y ☐ N | If yes, what do you smoke ?

Amount /day?

Do you drink alcohol? ☐ Y ☐ N | If yes, #of days /week? | # of drinks per day?

FAMILY HISTORY

Please indicate which, if any, family member has been diagnosed with the following:

Heart Disease: | Hypertension: | Diabetes:

Stroke: | Arthritis: | Osteoporosis:

Fibromyalgia: | Cancer: | Depression/Anxiety:

Please check if you have ever been diagnosed with any of the following problems, disorders or diseases:

☐ Osteoarthritis	☐ Rheumatoid Arthritis	☐ Head Trauma	☐ Seizures / Epilepsy	☐ Circulatory / Vascular
☐ Fibromyalgia	☐ Osteoporosis	☐ Stroke	☐ Cancer	☐ Bone/Joint Disorders
☐ Blood Disorders	☐ Lung Problems	☐ Kidney Disorder	☐ Thyroid Disorder	☐ Broken Bone/Fractures
☐ Hypertension	☐ Parkinson's Disease	☐ Skin Disorder	☐ Ulcer / Stomach	☐ Depression/Anxiety
☐ Diabetes	☐ Infectious Disease	☐ Heart Problems	☐ Multiple Sclerosis	☐ Muscle Wasting

Please list any allergies

Have you ever had any surgery? ☐ Y ☐ N | If yes, please list what type(s) and approimate date(s) of surgery:

FALLS

Do you have a history of falls? ☐ Y ☐ N

Please describe:

How many times have you fallen within the last year?

Were you injured? ☐ Y ☐ N

MOBILITY

Do you have stairs at home? ☐ Y ☐ N | If yes, are there hand rails? ☐ Y ☐ N

Do you have difficulty with any of the following:

☐ Stairs ☐ Ramps ☐ Curbs ☐ Uneven Terrain

Do you use any of the following assistive devices?

☐ Straight Cane	☐ Regular Walker	☐ Motorized Wheelchair
☐ Glasses	☐ Hearing Aid	☐ Manual Wheelchair
☐ Quad Cane	☐ Scooter	☐ UE or LE orthotic / splint
☐ Hemiwalker	☐ Rolling Walker	