

Essex Physical Therapy Health Intake Form

Date: _____

Name: _____ Date of Birth: _____

Primary Physician: _____ Referring Physician: _____

Describe briefly why you are here today. _____

When did the problem(s) begin? _____

Have you ever had the problem before? YES NO

What did you do for your Problem(s)? _____

Did the problem get better? YES NO

What are your goals for physical therapy? _____

With whom do you live? Alone Spouse only Spouse & others Child (no spouse)

Personal care attendant Group setting other _____

Employer or School: _____ Full-time Part-time

Occupation: _____ Grade in School: _____

Date of most recent physical: _____

Please rate your health: Excellent Good Fair Poor

Do you exercise? YES NO If yes, how often _____

What type? _____

Do you smoke? YES NO If yes, number per day _____

Cigarettes Cigars Pipes Other

Do you have any allergies? YES NO

If yes, to what? _____

(2)

Have you ever had surgery? YES NO

If yes, please describe and include

dates: _____

Do you have or use any assistive devices ? Cane Walker Wheelchair Other_____

Do you have or use: Glasses Hearing Aid

Medical History:

Do you have now or have you ever been diagnosed with:

Cancer

Arthritis

Broken Bones

Diabetes

Osteoporosis

Hypoglycemia

Head Injury

Heart Problems

Skin Diseases

Heart Disease

Multiple Sclerosis

Angina or chest pain

Muscular Dystrophy

Shortness of breath

Parkinson's Disease

Emphysema/Asthma

Seizures/ Epilepsy

**Hypertension or
High Blood Pressure**

Thyroid problems

Kidney problems

Blood Disorders

Ulcers/ Stomach Problems

Circulation Problems

Repeated infections

Stroke

Depression

(3)

Within the past year, have you had any of the following symptoms?

Chest Pain

Heart Palpitations

Cough

Hoarseness

Shortness of breath

Dizziness or blackouts

Coordination problems

Weakness in arms/legs

Loss of balance

Difficulty walking

Joint pain/swelling

Pain at night

Difficulty sleeping

Loss of appetite

Nausea/vomiting

Difficulty swallowing

Bowel problems

Weight loss/gain

Urinary problems

Fever/chills/sweats

Headaches

Hearing problems

Vision problems

Other_____

Please list any medications or herbal supplements you may be taking:

Have you seen anyone else for the problems that brought you here today? YES NO
If yes, who?_____

Is there anything not listed that you feel we should know to assist with your
treatment?_____
