

# PATIENT HISTORY / INTAKE 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	HEALTH HABITS
Do you have any customs or beliefs that might affect Care? <input type="text"/>	General Health: <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
Do you live with: <input type="checkbox"/> Alone <input type="checkbox"/> Spouse <input type="checkbox"/> Children <input type="checkbox"/> Other	Do you have an Advanced Directive (Living Will)? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unsure
Do you exercise beyond normal activities and chores? <input type="checkbox"/> Y <input type="checkbox"/> N	Do you smoke? <input type="checkbox"/> Y <input type="checkbox"/> N If yes, what do you smoke? <input type="text"/>
If yes, how many times per week? <input type="text"/> How many minutes? <input type="text"/>	Amount /day? <input type="text"/>
What type of exercise? <input type="text"/>	Do you drink alcohol? <input type="checkbox"/> Y <input type="checkbox"/> N If yes, #of days /week? <input type="text"/> # of drinks per day? <input type="text"/>

## FAMILY HISTORY

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

Heart Disease: <input type="text"/>	Hypertension: <input type="text"/>	Diabetes: <input type="text"/>
Stroke: <input type="text"/>	Arthritis: <input type="text"/>	Osteoporosis: <input type="text"/>
Fibromyalgia: <input type="text"/>	Cancer: <input type="text"/>	Depression/Anxiety: <input type="text"/>

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

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

Please list any allergies

Have you ever had any surgery?  Y  N If yes, please list what type(s) and approximate 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