HANDS ON HEALTHCARE INC

INTAKE FORM

Personal Information **Date:** __________

Name:________________________________ ________________________ _____
Last First initial

Address: ______________________________________ __________ ____ _______
Street City ST Zip

Phone(H)___________________________Phone(C)_________________________________

Email: _____________________________ Birthdate: _________ Age: _____ Sex: ______

Marital Status: S M W D If married Spouse name: ______________________________

Emergency Contact: ___________________________________ Phone: ________________

Family Doctor:____Phone:__________________

Referring Doctor:______________________________________Phone__________________

Occupation:_______________________________Currently working?________ Hrs/wk:_____

THE FOLLOWING IS VERY IMPORTANT IN THE EVALUATION PROCESS. PLEASE FILL OUT QUESTIONS AS SPECIFICALLY AS POSSIBLE TO PROVIDE A CLEAR PICTURE OF YOUR PRESENT FUNCTIONAL ABILITIES AND SYMPTOMS.

1. History of Illness/Injury.

Is injury related to : Work ________ Auto ________ Home________
Other ________

Date of injury/onset of symptoms: __________________________

Have you previously been treated for this problem? ________

Did it help? __________

What treatments did you receive? _______________________________________

Were x-rays taken? __________________ MRI? ___________________________

Results?____

2. What is your primary complaint that brings you to therapy? Please describe your symptoms as specifically as possible.

3. **What are your goals for Physical Therapy?** For example, what activities do you want to perform longer or better? How long in hours or minutes do you want/need to perform each activity?

4. Do you have a history of;

	Yes	No		Yes	No
Circulatory problems	___	___	Blackouts	___	___
High Blood Pressure	___	___	Visual disturbances	___	___
Heart trouble	___	___	Weight Changes (>15lbs)	___	___
Pacemaker	___	___	Headaches	___	___
Epilepsy	___	___	Ringing in ears	___	___
Diabetes	___	___	Bowel/Bladder Problems	___	___
Pregnancy	___	___	Malignancy	___	___
Stroke	___	___	Arthritis	___	___
Do you smoke?	___	___			

If so how many pks/day?___________

5. Please list any allergies ____
____

6. Medications currently taking ____
____
____
____

7. Past Medical History: Please list any surgeries, traumas, accidents, broken bones/ fractures or other conditions not previously listed.