MONIQUE KREBSBACH PT, INC. HEALTH INTAKE FORM

Name: _____ Primary Care Provider _____

DOB: _____ Age: _____ Height _____ Weight _____

Have you been hospitalized in the last year? If Yes, for _____

Reason for today's visit: _____

Is your visit related to an accident? Y/N If Yes, what is the date of accident/injury? _____

How long have your symptoms been bothering you? _____

Occupation/Do you sit at a desk for work? _____

Have you had any unexpected weight loss in the last several months? Yes No

MEDICAL HISTORY * Please circle any that apply

History of Falls? Yes No If Yes, how many times in the last year have you fallen? _____

Alzheimer's	History of Cancer	Asthma	Brain Injury
Cardiovascular Disease	Cerebral vascular Accident/Stroke		Headaches
Current Infection	Diabetes Mellitus Type I	Diabetes Mellitus Type II	
Fibromyalgia	High Blood Pressure	Lupus	Obesity
Parkinsons	Multiple Sclerosis	Heartburn	TMJ/Jaw pain
Depression	Ulcers	Epilepsy	Glaucoma
Swelling	Recent Weight Loss	Irritable Bowel/Colitis	
Hearing Loss	Tremors/shaking	Dizziness	Vision issues
HIV/AIDs	Pregnancy	Allergies _____	

Arthritis: Rheumatoid/Osteoarthritis Joints involved _____

Pulmonary/Breathing issues such as asthma/Short of Breath/COPD _____

Past Surgeries, including dates: _____

_____

Please list any recent xrays, MRI/CT scan, or other tests you have had in the last year:

_____

MEDICATIONS: Please list all medications/herbals/vitamins you may take. If you have a list, a copy can be made today. (Use back of sheet, if needed)

_____

_____

SOCIAL HISTORY: Smoking Never Past Current _____packs/day
Alcohol Never 1-2drinks/day 3 or more drinks/day 1-2 drinks/week
Caffeine _____

Activity: What do you like to do for exercise? Activity? _____

Function: Have you fallen in the last year? Yes No How many falls? _____

Were these related to medication? Vision? _____

Do you have a fear of falling? Yes No

Are you stiff in the morning? Yes No How long does it take to loosen up? _____

Which is easier – standing or sitting?

Is it hard to walk through the grocery store? Yes No

Is it hard to get off of the toilet? Yes No

Home Layout: 1-Story 2-Story Stairs/Steps How many? _____

Shower Stall Bathtub/shower combo Grab Bars? WC accessible?

Pain: Where do you have pain? _____

What is your average pain Level in the last week 0 1 2 3 4 5 6 7 8 9 10

What makes your pain worse? _____

What makes your pain better? _____

Is your pain better in AM or PM? Do you use heat? Ice? How often? _____

Do stairs increase your pain? Yes No

Does movement make your pain worse or better?

Do you have any night pain? Yes No

Is there anything else you would to let me know, in order to improve your Physical Therapy?

_____