Medical Intake Form

HOLMES PHYSICAL THERAPY

Please select each of the topics that relate to your medical history:

- ☐ Anemia
- ☐ Back Pain
- ☐ Bronchitis
- ☐ Drink alcohol
- ☐ Gout
- ☐ Hernia
- ☐ Parkinson's
- ☐ Severe/frequent headache
- ☐ Stroke/TIA
- ☐ Vision difficulties
- ☐ Women's health issues
- ☐ A pacemaker
- ☐ Angina
- ☐ Blood Clot/Emboli
- ☐ Coronary Heart Disease
- ☐ Emphysema
- ☐ Hearing Difficulties
- ☐ High Blood Pressure
- ☐ Pneumonia
- ☐ Sleeping Problems
- ☐ Thyroid Problems
- ☐ Weakness
- ☐ Allergies
- ☐ Asthma
- ☐ Bowel/Bladder problems
- ☐ Dizziness/Faintness
- ☐ Epilepsy/Seizures
- ☐ Heart Attack
- ☐ Kidney Disease
- ☐ Pregnant
- ☐ Smoke Cigarettes
- ☐ Varicose Veins
- ☐ Weight Loss/Energy Loss

Please select body area that is involved with your medical history:

☐ Ankles	☐ Right	☐ Left	☐ Both
☐ Elbows	☐ Right	☐ Left	☐ Both
☐ Hips	☐ Right	☐ Left	☐ Both
☐ Knees	☐ Right	☐ Left	☐ Both
☐ Legs	☐ Right	☐ Left	☐ Both
☐ Shoulders	☐ Right	☐ Left	☐ Both
☐ Wrists	☐ Right	☐ Left	☐ Both

Please select any of the following relate to your medical history:

☐ Numbness/Tingling/Neuropathy	Right/Left	Body Area:_____
☐ Arthritis	Right/Left	Body Area:_____
☐ Joint Replacement	Right/Left	Body Area:_____
☐ Pins/Metal Implant	Right/Left	Body Area:_____

Please select any of the following that relate to your medical history:

- ☐ CRPS
- ☐ Diabetes Type II
- ☐ Received HOME Physical Therapy
- ☐ I use a cane
- ☐ I use a wheelchair
- ☐ infectious disease
- ☐ Pelvic Floor Concerns
- ☐ Cancer
- ☐ Diabetes, Type I
- ☐ I am a caregiver for someone
- ☐ I live alone
- ☐ I use a walker
- ☐ Incontinence
- ☐ My home has stairs
- ☐ Other Surgery
- ☐ Vertigo/Balance

Does your diagnosis impact your ability to do your job or attend school? (Choose One)

Work

- ☐ I am retired
- ☐ The diagnosis prevents me from working
- ☐ I can only work part time
- ☐ I can work, but with great difficulty
- ☐ I can work, with minor difficulty
- ☐ The diagnosis does not impact my work
- ☐ Not Applicable

OR

School

- ☐ The diagnosis prevents me from attending school
- ☐ I'm in school, but the diagnosis has a big impact
- ☐ I'm in school and the diagnosis has minor impact
- ☐ School is normal, but I can't participate in sports
- ☐ School is normal, no impact

Does your daily routine, or work, aggravate your injury?

- ☐ No
- ☐ I am unable to participate in my normal routines or work
- ☐ My routine/work usually impacts my injury 1 day per week
- ☐ My routine/work usually impacts my injury 2 day per week
- ☐ My routine/work usually impacts my injury 3 day per week
- ☐ My routine/work impacts my injury every day, but I try to cope

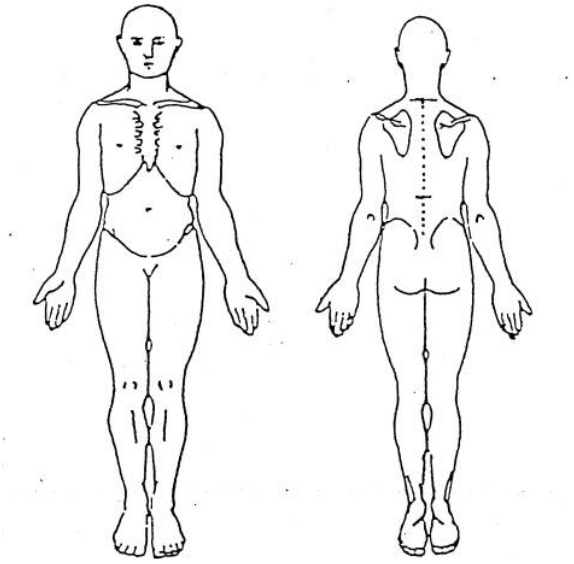
How often do you Exericse:

- ☐ Never
- ☐ Usually once per week
- ☐ Usually twice per week
- ☐ Usually 3 times per week
- ☐ 4 or more times per week

Please choose what describes your pain (select all that apply):

- ☐ Aching
- ☐ Burning
- ☐ Constant
- ☐ Cramping
- ☐ Deep
- ☐ Dull
- ☐ Heavy
- ☐ Numb
- ☐ Pins and Needles
- ☐ Stabbing
- ☐ Throbbing
- ☐ Variable
- ☐ Weak

Please place an 'X' or circle the body part(s) that prompted today's visit:



Is this a reoccurence of a prior injury:

☐ Yes ☐ No

If yes, what year was the prior injury? _____

Please rate the pain (0 = no pain, 10 = worst pain I've ever felt):

Current:	0	1	2	3	4	5	6	7	8	9	10
At Best:	0	1	2	3	4	5	6	7	8	9	10
At Worst:	0	1	2	3	4	5	6	7	8	9	10

Please list all the medications you are currently taking:

Medication Name:	Quantity			Route		Frequency	
EXAMPLE: Tylenol	800	☒ Pill ☐ Teaspoon ☐ Tablespoon ☐ gram (g)	☐ milligram ☐ cc(s) ☐ milliters (ml) ☐ drops	☒ Swallowed ☐ Cream ☐ Injected ☐ Nasal	3 X	☐ Hour ☒ Day ☐ Week ☐ Month ☐ As Needed
1.		☐ Pill ☐ Teaspoon ☐ Tablespoon ☐ gram (g)	☐ milligram ☐ cc(s) ☐ milliters (ml) ☐ drops	☐ Swallowed ☐ Cream ☐ Injected ☐ Nasal	X	☐ Hour ☐ Day ☐ Week ☐ Month ☐ As Needed
2.		☐ Pill ☐ Teaspoon ☐ Tablespoon ☐ gram (g)	☐ milligram ☐ cc(s) ☐ milliters (ml) ☐ drops	☐ Swallowed ☐ Cream ☐ Injected ☐ Nasal	X	☐ Hour ☐ Day ☐ Week ☐ Month ☐ As Needed
3.		☐ Pill ☐ Teaspoon ☐ Tablespoon ☐ gram (g)	☐ milligram ☐ cc(s) ☐ milliters (ml) ☐ drops	☐ Swallowed ☐ Cream ☐ Injected ☐ Nasal	X	☐ Hour ☐ Day ☐ Week ☐ Month ☐ As Needed
4.		☐ Pill ☐ Teaspoon ☐ Tablespoon ☐ gram (g)	☐ milligram ☐ cc(s) ☐ milliters (ml) ☐ drops	☐ Swallowed ☐ Cream ☐ Injected ☐ Nasal	X	☐ Hour ☐ Day ☐ Week ☐ Month ☐ As Needed
5.		☐ Pill ☐ Teaspoon ☐ Tablespoon ☐ gram (g)	☐ milligram ☐ cc(s) ☐ milliters (ml) ☐ drops	☐ Swallowed ☐ Cream ☐ Injected ☐ Nasal	X	☐ Hour ☐ Day ☐ Week ☐ Month ☐ As Needed
6.		☐ Pill ☐ Teaspoon ☐ Tablespoon ☐ gram (g)	☐ milligram ☐ cc(s) ☐ milliters (ml) ☐ drops	☐ Swallowed ☐ Cream ☐ Injected ☐ Nasal	X	☐ Hour ☐ Day ☐ Week ☐ Month ☐ As Needed
7.		☐ Pill ☐ Teaspoon ☐ Tablespoon ☐ gram (g)	☐ milligram ☐ cc(s) ☐ milliters (ml) ☐ drops	☐ Swallowed ☐ Cream ☐ Injected ☐ Nasal	X	☐ Hour ☐ Day ☐ Week ☐ Month ☐ As Needed
8.		☐ Pill ☐ Teaspoon ☐ Tablespoon ☐ gram (g)	☐ milligram ☐ cc(s) ☐ milliters (ml) ☐ drops	☐ Swallowed ☐ Cream ☐ Injected ☐ Nasal	X	☐ Hour ☐ Day ☐ Week ☐ Month ☐ As Needed
9.		☐ Pill ☐ Teaspoon ☐ Tablespoon ☐ gram (g)	☐ milligram ☐ cc(s) ☐ milliters (ml) ☐ drops	☐ Swallowed ☐ Cream ☐ Injected ☐ Nasal	X	☐ Hour ☐ Day ☐ Week ☐ Month ☐ As Needed

What makes your pain **worse**? (check all that apply):

- ☐ Reaching back
- ☐ Lying flat
- ☐ Getting up out of bed
- ☐ Dressing and grooming
- ☐ Cooking
- ☐ Carrying items
- ☐ Climbing stairs
- ☐ Lifting anything
- ☐ Lifting heavy weights
- ☐ Pulling
- ☐ Raising arm over the head
- ☐ Looking up/down
- ☐ Walking

What **relieves** your pain? (check all that apply):

- ☐ Ice
- ☐ Heat
- ☐ Stretching
- ☐ Exercise
- ☐ Pain medication
- ☐ Lying flat
- ☐ Avoiding activity
- ☐ Nothing

How many times have you fallen in the past year?

- ☐ 0 times
- ☐ 1 times
- ☐ 2 times
- ☐ 3 times
- ☐ 4 times
- ☐ 5 times
- ☐ 6 or more

Were you injured: ☐ Yes ☐ No

About tobacco use, do you:

- ☐ Smoke tobacco
- ☐ Chew tobacco
- ☐ Snufff tobacco
- ☐ all of the above
- ☐ none of the above

Have you received counseling to help stop using tobacco: ☐ Yes ☐ No

Name: _____ Date of Birth: ___ /___ /_____

Height: ____ ft ____ in Weight: _____ lbs

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