

**Active Rehab Services Inc. DBA: Active Fitness & Physical Therapy**

**Patient Name:** \_\_\_\_\_ **Date** \_\_\_\_\_

**Medical History Intake Form**

**Existing Conditions**

Allergies <input type="radio"/> Yes <input type="radio"/> No	Dizzy Spells <input type="radio"/> Yes <input type="radio"/> No	MRSA <input type="radio"/> Yes <input type="radio"/> No
Anemia <input type="radio"/> Yes <input type="radio"/> No	Emphysema/Bronchitis <input type="radio"/> Yes <input type="radio"/> No	Osteoporosis <input type="radio"/> Yes <input type="radio"/> No
Anxiety <input type="radio"/> Yes <input type="radio"/> No	Fractures <input type="radio"/> Yes <input type="radio"/> No	Parkinson's <input type="radio"/> Yes <input type="radio"/> No
Arthritis <input type="radio"/> Yes <input type="radio"/> No	Gallbladder Problems <input type="radio"/> Yes <input type="radio"/> No	Rheumatoid Arthritis <input type="radio"/> Yes <input type="radio"/> No
Asthma <input type="radio"/> Yes <input type="radio"/> No	Hearing Impairments <input type="radio"/> Yes <input type="radio"/> No	Seizures <input type="radio"/> Yes <input type="radio"/> No
Autoimmune Disorder <input type="radio"/> Yes <input type="radio"/> No	Hepatitis <input type="radio"/> Yes <input type="radio"/> No	Smoking <input type="radio"/> Yes <input type="radio"/> No
Cancer <input type="radio"/> Yes <input type="radio"/> No	High Cholesterol <input type="radio"/> Yes <input type="radio"/> No	Speech Problems <input type="radio"/> Yes <input type="radio"/> No
Cardiac Conditions <input type="radio"/> Yes <input type="radio"/> No	High/Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Strokes <input type="radio"/> Yes <input type="radio"/> No
Cardiac pacemaker <input type="radio"/> Yes <input type="radio"/> No	HIV/AIDS <input type="radio"/> Yes <input type="radio"/> No	Thyroid disease <input type="radio"/> Yes <input type="radio"/> No
Chemical Dependency <input type="radio"/> Yes <input type="radio"/> No	Incontinence <input type="radio"/> Yes <input type="radio"/> No	Tuberculosis <input type="radio"/> Yes <input type="radio"/> No
Circulation Problems <input type="radio"/> Yes <input type="radio"/> No	Kidney Problems <input type="radio"/> Yes <input type="radio"/> No	Vision Problems <input type="radio"/> Yes <input type="radio"/> No
Currently Pregnant <input type="radio"/> Yes <input type="radio"/> No	Metal Implants <input type="radio"/> Yes <input type="radio"/> No	
Depression <input type="radio"/> Yes <input type="radio"/> No	Multiple Sclerosis <input type="radio"/> Yes <input type="radio"/> No	Height: _____
Diabetes <input type="radio"/> Yes <input type="radio"/> No	Muscular Disease <input type="radio"/> Yes <input type="radio"/> No	Weight: _____

**Do you have any of the following conditions? Please check all that apply.**

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> Irritable Bowel     | <input type="checkbox"/> Blood clots/Phlebitis | <b><u>Skin</u></b>                     | <b><u>Psychological</u></b>                     |
| <input type="checkbox"/> Fibromyalgia        | <input type="checkbox"/> COPD                  | <input type="checkbox"/> Eczema        | <input type="checkbox"/> Anxiety/Panic Disorder |
| <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Shingles              | <input type="checkbox"/> Psoriasis     | <input type="checkbox"/> Schizophrenia          |
| <input type="checkbox"/> Jaw Pain/TMJ        |  | <input type="checkbox"/> Latex Allergy | <input type="checkbox"/> Bipolar Disorder       |
| <input type="checkbox"/> Concussion/TBI      |  |  | <input type="checkbox"/> PTSD                   |
| <input type="checkbox"/> Hernia              |  |  |   |

Please provide details regarding conditions checked above: \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

**Fall History**

Have you been injured as a result of a fall in the past year?  Yes  No      Have you fallen recently?  Yes  No

Have you fallen two or more times in the past year?  Yes  No

**Surgical History**

Body Region \_\_\_\_\_ Surgery Type \_\_\_\_\_ Date : \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Body Region \_\_\_\_\_ Surgery Type \_\_\_\_\_ Date : \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**Please list or provide a list of any PRESCRIPTION medication you are currently taking.**

Drug: \_\_\_\_\_ Dosage: \_\_\_\_\_ Frequency: \_\_\_\_\_ Reason taking: \_\_\_\_\_

Drug: \_\_\_\_\_ Dosage: \_\_\_\_\_ Frequency: \_\_\_\_\_ Reason taking: \_\_\_\_\_

**OVER →**

Name: \_\_\_\_\_ Date \_\_\_\_\_

Describe why you are here. This will help the PT find the underlying cause of your pain:

Where is your pain/problem? :

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Pain Description: (Circle all that apply)

Sharp      Achy      Numb/Tingling      Constant      Intermittent      N/A

WORST your pain has been in the past week? (0 = no pain, 10 = worst pain)

1      2      3      4      5      6      7      8      9      10

What aggravates/causes your pain? Sitting? Bending? Walking? What movements or activities?

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How long have you been affected by this problem? \_\_\_\_\_

What does this stop you from being able to do? What activities? \_\_\_\_\_

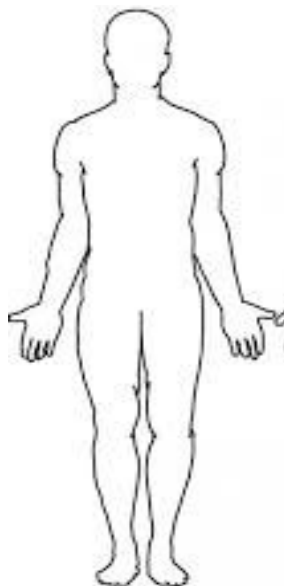
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What would you like to be able to do? \_\_\_\_\_

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**Mark or color in the areas of pain on the diagram below:**

Front



Back

