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

Patient Name: _____ Date_____

Medical History Intake Form

Existing Conditions

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

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

____Irritable Bowel
____Fibromyalgia
____Headaches/Migraines
____Jaw Pain/TMJ
____Concussion/TBI
____Hernia

____Blood clots/Phlebitis
____COPD
____Shingles

Skin
____Eczema
____Psoriasis
____Latex Allergy

Psychological
____Anxiety/Panic Disorder
____Schizophrenia
____Bipolar Disorder
____PTSD

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? :

_____

_____

Pain Description: (Circle <u>all</u> 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?

_____

_____

How long have you been affected by this problem? _____

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

_____

What would you like to be able to do? _____

_____

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

Front **Back**