HOLISTIC PHYSICAL THERAPY & WELLNESS

Confidential OT/PT Intake Form

Name:_____

Today's Date: _____

Date of Birth:_____

Age:_____**Height:**_____**Weight:**_____

Occupation: _____

What brings you in for therapy and what are your current complaints/limitations?

_____

_____

Do you have a history with these same complaints; how and when did they begin?

_____

_____

Identify up to 3 important positions or activities that make your symptoms:

Increase:_____

Decrease:_____

What are your goals for working with us?

_____

Please inform us of any environmental or living conditions that are difficult:

_____

List prescribed medications: NAME, DOSAGE, FREQUENCY (more than 3 meds, write on back)

_____

_____

List your leisure activities and any exercise routines that you do regularly:

_____

_____

Daily Intake - Alcohol Drinks:_____**Tobacco:**_____**Joints/Edibles:**_____

If you have suffered abuse (sexual, physical, emotional) please explain to the extent that you wish:

_____

_____

Do you have any allergies to any lotions, oils, or latex: ***YES***_____ ***NO*** _____ **If yes, please list:**

_____

Do you have a pace maker: ***YES***_____ ***NO*** _____

Do you wear contact lenses: ***YES***_____ ***NO*** _____

Do you wear dentures: ***YES***_____ ***NO*** _____

Mark the following areas of disease or symptoms. Use C = current or P = past. More space is available for explanation on side 2 of this form.

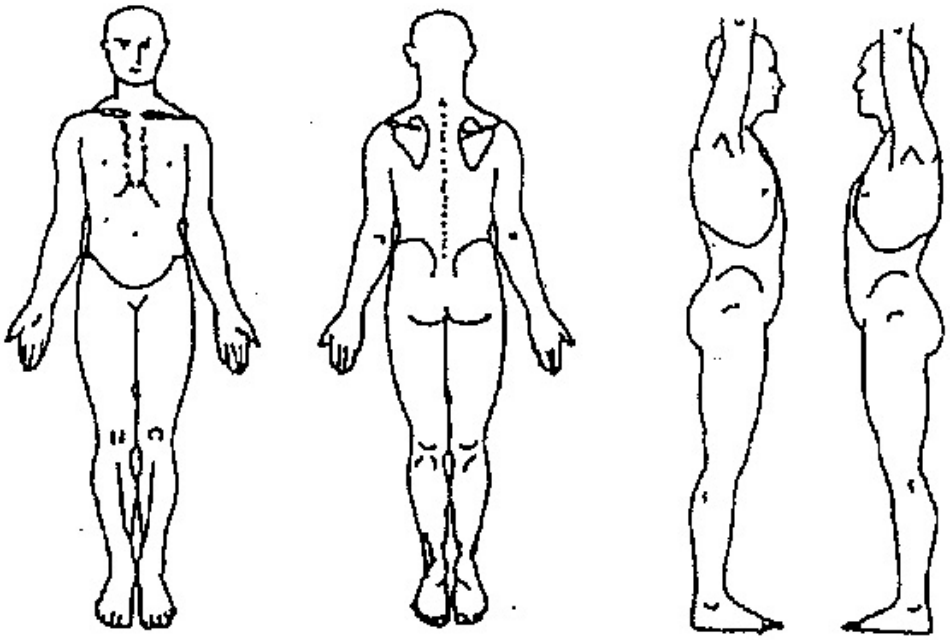
Emotional / Mental	**Endocrine**	**Cardiovascular**	**Reproductive**
Depression	Adrenal	Angina	STD's
Eating Disorder	Pituitary	Stroke	Endometriosis
Mood Swings	Hyperthyroid	Heart Attack	Miscarriage(s)
Substance Abuse	Hypothyroid	Hypertension	Abortion(s)
Anxiety	**Neurological**	**Respiratory**	Female Organs
OCD	Epilepsy	Bronchitis	**Abuse**
Mental Illness	Dizziness	Emphysema	Sexual Abuse
Auto-Immune	Insomnia	Pneumonia	Physical Abuse
Fatigue	Migraines	Tuberculosis	Mental Abuse
Fever (severe)	**Muscular-Skeletal**	**Digestion**	**Urinary**
Fibromyalgia	Arthritis	Constipation	Bladder infection
Fungal Infections	Back Pain	Diabetes	Kidney Stones
Herpes	Carpal Tunnel	Diarrhea	**Other**
Lyme Disease	Gout	Hepatitis	
Mononucleosis	Skin Disorder	Hypoglycemia	
AIDS / HIV	**Ear, Nose, Throat**	Jaundice	
Allergies	Earache	Ulcer	
Cancer	Jaw Pain (TMJD)	Liver Disorder	

List any other medical history, accidents, and surgeries not listed above or give more detail:

_____

_____

_____



<u>Mark on the above, areas of pain, tension, or change in sensation.</u>
0 is no symptoms and 10 is unbearable symptoms.
Symptoms at rest 0-10 _____ Symptoms with activity 0-10 _____