

PHYSICAL THERAPY AND SPORTS PERFORMANCE, LLC
298 North Hwy 16
Suite C

MEDICAL INTAKE FORM

Patient _____ SS#: _____
 Date of Birth: _____
 Emergency Contact: _____
 Relationship: _____ Telephone #: _____
 Referring Physician: _____ Telephone #: _____
 Family Physician / Internist: _____ Telephone #: _____

MEDICAL INFORMATION: TO THE BEST OF YOUR KNOWLEDGE, DO YOU HAVE / HAVE HAD :

- | | | | | | |
|-------------------------------|-----|----|--------------------------------|-----|----|
| 1. High Blood Pressure | yes | no | 28. Blood in Stool / Ulcers | yes | no |
| 1. Heart Disease Heart Attack | yes | no | 29. Abdominal Pain | yes | no |
| 2. Chest Pains / Angina | yes | no | 30. Thyroid Problems | yes | no |
| 3. High Cholesterol | yes | no | 31. Polio / Muscle Disease | yes | no |
| 4. Pacemaker | yes | no | 32. Seizures | yes | no |
| 5. Shortness of Breath | yes | no | 33. Migraine/Cluster Headaches | yes | no |
| 6. Asthma | yes | no | 34. TMJ Disorders | yes | no |
| 7. Allergies | yes | no | 35. Chills/Fever/Sweats | yes | no |
| 8. Chronic Bronchitis | yes | no | 36. Chronic Headaches | yes | no |
| 9. Blood Disorders | yes | no | 37. Swelling of Extremities | yes | no |
| 10. Emphysema | yes | no | 38. Sleep Disorders | yes | no |
| 11. Bleeding/Bruising | yes | no | 39. Depression | yes | no |
| 12. Anemia | yes | no | 40. Fibromyalgia | yes | no |
| 13. Diabetes | yes | no | 41. Chronic Fatigue Syndrome | yes | no |
| 14. Hypoglycemia | yes | no | 42. Lyme's Disease | yes | no |
| 15. Lightheadedness | yes | no | 43. Chronic Pain | yes | no |
| 16. Dizziness | yes | no | 44. Night Pain | yes | no |
| 17. Concussion | yes | no | 45. Unexplained Pain | yes | no |
| 18. Fainting Disorders | yes | no | 46. Unexplained Weight Loss | yes | no |
| 19. Anxiety/Panic Attacks | yes | no | 47. Cancer/Tumors/Growths | yes | no |
| 20. Arthritis/Joint Pain | yes | no | 48. History of Smoking | yes | no |
| 21. Artificial Joints | yes | no | 49. Are you pregnant? | yes | no |
| 22. Kidney Disease/Stones | yes | no | 50. Gynecological Disorders | yes | no |
| 23. Hepatitis | yes | no | 51. Bladder Incontinence | yes | no |
| 24. Spinal Cord Injury | yes | no | 52. Bowel Incontinence | yes | no |
| 25. Traumatic Brain Injury | yes | no | 53. Fractures | yes | no |
| 26. Ulcers | yes | no | | | |

Date: _____ Area: _____
 Date: _____ Area: _____

CURRENT MEDICATIONS: _____

ALLERGIES:

A. To Medications: _____

A. To Other Substances: _____

SURGERY (S) Include Dates: _____

X-RAYS, MRI, CAT SCANS (Include Area & Dates): _____

SIGNATURE: _____ Date: _____