Medical History and Intake Form

Date:___________________________

Name:____Date of Birth____
Referring Provider:____________________________________Reason for Referral:__________________________________
Primary Care Provider:________________________________
Name and relationship of person completing this from (if person is not patient) ______________________________________

Current symptoms:

Fatigue	Eye pain	Bowel accidents	Need for cane/ walker/ wheelchair	Trouble with walking
Fever	Chest pain	Bladder accidents	Headache	Falling
Weight loss	Palpitations	Urgency of urine	Memory loss	Other symptoms:
Weight gain	Fainting	Pregnancy	Numbness	____________________
Accidents	Heart Problems	Impotence	Tingling	____________________
Smoking	Shortness of breath	Depression	Tremor	____________________
Vision changes	Trouble with sleep	Anxiety	Seizure	____________________
Double vision	Snoring	Hallucinations	Weakness	____________________
Vision loss	Morning fatigue	Anemia		____________________

Medical Problems

Alzheimer's	Dementia	Heart Disease	Surgery_____________	Other_______________
Parkinsons	Migraine	High Blood Pressure	____________________	____________________
Multiple Sclerosis	Head injury	Anemia	___________________	____________________
Epilepsy	Neck injury	Osteoporosis	____________________	____________________
Neuropathy	Tremor	Sleep Apnea	____________________	____________________
Stroke/TIA	Cancer	Fibromyalgia		____________________
Toticollis	Thyroid	Asthma		____________________
Spasticity	Diabetes			

Family Health: List known medical conditions for family members:

Mother:____
Father:____
Siblings:____
Grandparents:____
Other:____

Current Medications and Supplements taken:

____
____
____
____
____

Drug Allergies:

____

Social History:

Job:______________________________
Education:________________________ Children:_________________________ Alcohol amount________________
MaritalStatus:______________________ Tobacco Y N quit____________ Exercise _______________________
Children:_________________________ Ever use recreational drugs? Y N