Medical History/Intake Form

Instructions: Please fill out the following information as directed below. All information is required unless otherwise noted by an *. If you have any questions please reach out to us via phone/email:

Phone: 260 255 6494 | Email: lucian@atpfortwayne.com

Print: Last Name: _____ First Name: _____ *Sex: _____

Date of Birth (MM/DD/YYYY): ____ /____ /_____ Marital Status: _____

CPreferred Contact Method: ☐ Phone Call ☐ Text ☐ E-mail

Please list: Phone Number to call/text: (_____)-_____-_____ E-mail: _____

Address: _____

Emergency Contact(s): Name: _____ Relationship: _____

How do we contact them? (phone #'s) 1. (_____)-_____-_____ *2. (_____)-_____-_____

*Primary Care Physician's Name: _____

*Occupation (If retired give previous occupation please): _____

Allergies/Medical Precautions: _____

Do you have Medicare (supplemental)/Medicaid? ☐ No ☐ Yes (type): _____

Patient Questionnaire/History

Preferred name you would like me to address you by: _____

*List your hobbies: _____

What is your chief complaint/issue? _____

What is/are your goal(s) you hope to achieve?

1. _____

2. _____

As you go about your day to day life do you have any pain you experience? ☐ Yes ☐ No

If YES please rate your pain (0 = none - 10 severe) ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Where do you have pain? _____ When did this start? _____

Have you sought medical attention? _____ If YES please list: _____

What makes the pain worse? _____ Better? _____

IF this pain is not a primary concern related to your goals above, would you like information, resources, and/or evaluation/treatment for this? ☐ Yes ☐ No

Patient Questionnaire/History Continued

Do you currently use an assistive device? ____ If YES, ☐ Cane (single point) ☐ Cane (3/4 point) ☐ Rolling Walker (2 wheels front) ☐ Rollator (4 wheels/seat) ☐ Wheelchair (Electric or manual) ☐ Crutches

Other or 2 devices (please describe): _____

Have you had any falls in the last year? ☐ Yes ☐ No

If YES, how many falls have you had? ____ Have you sustained an injury from a fall? _____

*What do you think caused the fall(s)? _____

Medical: Please answer the following with an "x" in the column indicating appropriately ----- Yes No

Do you currently have issues interrupting your sleep such as pain, night sweats, chills?	☐	☐
Have you had any recent changes in bowel or bladder function?	☐	☐
Do you experience dizziness or vertigo?	☐	☐
Have you had any recent unplanned changed in weight or appetite?	☐	☐
Do you have any intolerance to hot or cold?	☐	☐
Do you have any bleeding or bruising disorders?	☐	☐
Have you had any skin changes, such as rash or discoloration?	☐	☐
Have you experience any recent visual changes or disturbances?	☐	☐
Have you had any recent episodes of nausea or vomiting?	☐	☐
Are you pregnant?	☐	☐
Do you have osteoporosis? Date of last bone scan:	☐	☐

Do you have any allergies?	☐	☐
Have you had any shortness of breath or chest pain recently?	☐	☐
Do you have high blood pressure?	☐	☐
Do you have any cardiac problems?	☐	☐
Do you have diabetes?	☐	☐
Have you ever had cancer of any sort?	☐	☐
Do you have a history of neck or back problems?	☐	☐

Have you had any imaging studies in the past 6 months? (describe type/results)

ex: MRI, neck, bulging disc: _____

Have you ever had any type of surgery? (please list clearly and date if possible)

_____

_____

Please clearly list **ALL** current prescribed medications, over the counter medications and supplements:

Social History

Does anyone in your immediate family (mother, father, siblings) have a history of Diabetes, High Blood Pressure, Heart Problems, or Cancer? _____

_____

*Do you have a legal guardian or healthcare power of attorney? ____ If YES who: _____

*Please rate your emotional/physical stress in your life right now: (0 = none - 10 = severe)

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

*Type of stressor/description? (physical demand/emotional):

_____

_____

_

Overall activity level on a weekly basis: (please circle number of days per week you perform an activity)

Walking at least 30min: 1 2 3 4 5 6 7 Approximate Hrs/wk: ____

Hobbies (gardening/golf etc): 1 2 3 4 5 6 7 Approximate Hrs/wk: ____

Exercise (gym, YMCA, yoga etc) 1 2 3 4 5 6 7 Approximate Hrs/wk: ____

Sitting/Resting (Watching TV, reading) 1 2 3 4 5 6 7 Approximate Hrs/wk: ____

Describe your typical diet: briefly state typical items you eat for each meal or if you eat out (where?)

Meal:	Weekday	Weekend
Breakfast		
Lunch		
Dinner		

What time do you generally go to bed at night? _____ Wake up in the morning? _____

*Do you own any pets? (If YES please note how many and type) _____

Use of Tobacco? (If NO please note if you have used in the past and for how long) _____

Use of Alcohol? (*If YES please note type/how much) _____