SENIORITY WELLNESS
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New Patient Intake Form

Client Name_____ DOB:_____
Address:_____
Phone#_____Email:_____
Occupation:_____
Emergency Contact Name & Phone number_____
Primary Care Physician Name & Phone number_____
Reason for PT Referral

Have you had any diagnostic, medical or rehab testing/procedures done in the past pertaining to this issue?

Have you had any Falls and Falls Related injuries?

Are you fearful of Falling?

Are you experiencing any pain?

What Prescription and/or over the counter medications are you currently taking?

Do you Engage in Regular Exercise?

What type and how often?

Have you been prescribed exercises by a physical therapist in the past? For what reason?

What are your current goals for Physical Therapy?

Ph: 513-799-8263 Fax: 513-912-0993 Email:info@senioritywc.com

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Do you have any of the following as part of your medical history? Check appropriate Boxes

Cardiac

- ☐ Atrial Fribrillation
- ☐ Congestive Heart Failure
- ☐ Coronary Artery Diseas
- ☐ High Blood Presure
- ☐ Pacemaker/Defibrillator
- ☐ Blood Clots
- ☐ Myocardial Infarction
- ☐ Arrthymias

Respiratory

- ☐ COPD
- ☐ Emphysema
- ☐ Asthma
- ☐ Pneumonia
- ☐ Pulmonary Embolism

Endocrine

- ☐ Diabetes Type__
- ☐ Hyperthyroid (overactive)
- ☐ Hypothyroid (underactive)
- ☐ COPD

Gastrointestinal

- ☐ GERD/Refulx
- ☐ Hiatal Hernia
- ☐ Irritable Bowel Syndrome
- ☐ Ulcerative Colitis/Chrons
- ☐ Diverticulitis
- ☐ Hepatitis
- ☐ Liver disease
- ☐ Pancreatic Disease

Neurologic

- ☐ Parkinsons Disease
- ☐ CVA/ TIA's
- ☐ Traumatic Brain Injury
- ☐ Brain Tumor
- ☐ Epilepsy/Seizures
- ☐ Chronic Headaches/Migraines
- ☐ Multiple Sclerosis
- ☐ Dementia Type_____

Urinary/Nephrology

- ☐ Urinary Tract Infections
- ☐ Urinary Incontinence
- ☐ Kidney stones
- ☐ Kidney Failure Stage__
- ☐ Dialysis

Cancer_____

Radiation?
Chemo?
Lymphedema Tx?

Musculoskeletal

- ☐ Joint Replacement _____
- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis
- ☐ Osteoporosis
- ☐ Spine Problems_____
- ☐ Gout
- ☐ Fracture History ____
- ☐ Soft Tissue Injury
- ☐ Rotator Cuff Tear/Shoulder issues__
- ☐ Foot/Ankle Problems

Mental Health

- ☐ Depression
- ☐ Anxiety
- ☐ Difficulty Sleeping
- ☐ Bipolar Disorder

Other Conditions

_____
_____
_____

Surgical History

_____
_____
_____
_____

I have truthfully answered the questions and completed my health history form to the best of my knowledge

Client Signature_____ Date: _____

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