SPAULDING
OUTPATIENT CENTERS

PATIENT INTAKE FORM

Name:_____

What condition brings you to therapy (in your own words)?:_____

MEDICAL HISTORY:
Prior surgeries/injuries?_____

_____

Recent hospital visits or stays?_____

List ALL Allergies

List all CURRENT Medications/Supplements

- ☐ **Check if you have been the victim of physical, sexual or verbal abuse in the past 12 months.**
- ☐ **Check if you feel unsafe at home due to abuse and neglect.**
- ☐ **Check if you are a parent or guardian completing this form on behalf of a patient.**
- ☐ **Check if you have fallen in the past 3 months**
- ☐ **Check if you are currently pregnant**

Check ALL the medical conditions that apply to you

	Allergic rhinitis		Genital Herpes		Neuropathy
	Anemia		GERD		Obesity
	Anxiety		Glaucoma		Osteoporosis
	Arthritis		Headache-migraine		Pneumonia
	Asthma		Heart Disease		Pregnancy
	Back injury		Heart Murmur		Peptic Ulcer Disease
	Cancer		Hepatitis		Pulmonary Embolism
	Congestive Heart Failure		HIV/AIDS		Recurrent Upper Respiratory Infection
	Concussion		HPV Infection		Seizure Disorder
	COPD		Hypertension		Skin Disease
	Coronary artery disease		Hypoglycemia		Sleep Apnea
	Chrohn's disease		Incontinence		Stroke
	Depression		Lung Disease		Substance Abuse
	Developmental/growth problems		Myocardial Infarction		Thyroid Disease
	Diabetes Mellitus		Myopathy/Muscle Disease		Ulcerative Colitis
	Enlarged Prostate		Nerve Neck Injury		Vascular Disease
	Fractures		Other:		Other: