SPAULDING OUTPATIENT CENTERS

**Patient Information:**

## 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

| | | | |
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| | | | |
| | | | |

### List all CURRENT Medications/Supplements

| | | | |
|---|---|---|---|
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- ☐ **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 | | Osteopenia |
| | Arthritis | | Headache-migraine | | Pneumonia |
| | Asthma | | Heart Disease | | Pregnancy |
| | Back injury | | Heart Murmur | | PUD |
| | Cancer | | Hepatitis | | Pulmonary Embolism |
| | CHF | | HIV/AIDS | | Recurrent URI |
| | Chronic Kidney Disease | | HPV Infection | | Seizure Disorder |
| | Concussion | | 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 | | Neck Injury | | Ulcerative Colitis |
| | Enlarged Prostate | | Nerve/Muscle Disease | | Vascular Disease |
| | Fractures | | | | |

- ☐ **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.**