



Denver Physical Therapy, P.C.
MEDICAL HISTORY INTAKE

Family and Personal History

Date: _____

Name: _____ DOB: _____ Age: _____

Diagnosis: _____

Past Medical History

Please check if either you or your immediate family member ever been told you have any of the following?

Circle One:

	Patient		Family			Patient		Family	
	Yes	No	Yes	No		Yes	No	Yes	No
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Angina/Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cardiac Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If yes, please explain. _____

	Patient		Family			Patient		Family	
	Yes	No	Yes	No		Yes	No	Yes	No
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma/ Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic/Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Urinary Tract Infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis/Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cirrhosis/Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If yes, please explain. _____

	Patient		Family			Patient		Family	
	Yes	No	Yes	No		Yes	No	Yes	No
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chemical Dependency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(Alcohol/drugs)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers/Stomach Issues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Migraine Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If yes, please explain. _____

	Patient		Family			Patient		Family	
	Yes	No	Yes	No		Yes	No	Yes	No
Arthritis/Gout	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fibromyalgia/Myofascial	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If yes, please explain. _____

Are there any other medical conditions we should know about? Yes No

If yes, please list and explain. _____

--Turn page over--



Denver Physical Therapy, P.C.

General Health

	No	Yes
1. Are you taking any prescription or over the counter medications (including supplements)? If yes, please list _____		
2. Have you had any illnesses within the last 3 weeks? (e.g. colds, influenza, bladder /kidney infection)		
3. Have you had an unexplained weight loss or gain in the last month?		
4. Are you pregnant?		
5. Do you smoke or chew tobacco? If yes, how many packs a day? _____ For how many years? _____		
6. Do you have any urine leaking? (e.g. with coughing, sneezing or exercising)		
7. How much caffeine do you consume daily? (e.g. coffee, tea, soda pop, or chocolate) _____ # of drinks		

Work Environment

Occupation: _____

Does your job involve:

- Prolonged sitting (e.g. desk, computer, driving)
- Prolonged standing (e.g. equipment operator, sales clerk)
- Prolonged walking (e.g. delivery service)
- Use of small or large equipment (e.g. telephone, typewriter, cash register, forklift, drill press)
- Lifting, twisting, bending, climbing, turning
- Exposure to chemicals, pesticides, toxins or gases
- Other: please describe: _____

Do you use any of the following?

- Back cushion, neck cushion
- Back brace or corset
- Other kind of brace or support for any body part (please list: _____)

History of Falls *please check all that apply*

- I have had no falls
- I have just started to lose my balance/fall
- I fall occasionally
- I fall frequently (more than twice during the past 6 months)
- Certain factors make me cautious (e.g. curbs, ice, stairs, getting in and out of the tub)

Medical Testing

	No	Yes
1. Have you had any x-rays, sonograms, CT scans, or MRIs done recently? If yes, when? _____ Which body region? _____ Results? _____		
2. Have you had any laboratory tests recently (urinalysis or blood test)? If yes, when, _____ What test? _____ Results? _____		

3. Please list any operations you have had and the date(s):

Operation	Date