



Patient Name _____ Date of Birth ____/____/____
Address _____ Phone: Home (____)____/____
_____ Cell (____)____/____
Email _____ Office (____)____/____

Emergency Contact: _____ Phone: (____)____/____
Spouse's Name (if primary cardholder) _____
Spouse's Birthdate _____
Date of Injury _____

Was your injury the result of a motor vehicle accident? ____
Who referred you to Village Physical Therapy? _____
If a minor, person responsible for the patient _____
Relationship _____

HEALTH INTAKE

Last Physical ____/____/____

Check if you have been diagnosed with any of the following:

- | | |
|------------------------------------|---|
| Arthritis _____ | Poor Circulation _____ |
| Asthma _____ | Seizures _____ |
| Cancer _____ | Stomach Problems (ulcer) _____ |
| Depression _____ | Thyroid Problems _____ |
| Diabetes _____ | Men Only: Prostate Disease _____ |
| Falls /Unsteadiness _____ | Women Only: Pregnant _____ |
| Fracture/Dislocation _____ | Endometriosis _____ |
| Head Injury _____ | Pelvic Floor Dysfunction _____ |
| Heart Conditions _____ | |
| High Blood Pressure _____ | |
| Kidney Problems _____ | |
| Liver Trouble _____ | |
| Lungs Problems _____ | |
| Joint Pain/swelling _____ | |
| Low Bone Density _____ | |
| Neurologic Problems (stroke) _____ | |

Have you recently experienced?:

Bowel/Bladder changes _____

Constant Pain _____

Fever (chills) _____

Unexplained weight loss/gain _____

Unexplained fatigue _____

Night pain _____

Numbness/Tingling _____

Cough _____

Shortness of Breath _____

New episodes of Headaches _____

Visual Changes _____

Hoarseness _____

Hearing difficulties _____

Chest Pain _____

Dizziness _____

Weakness _____

Difficulty Walking _____

Smoking Cigarettes _____

Other Medical Conditions _____

Hospitalizations/Surgeries _____

Current Medications:

Allergies: _____