TRUE NORTH
PHYSICAL THERAPY AND WELLNESS

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PATIENT INTAKE INFORMATION:

Date:_____

Name:_____

Date of Birth:_____

Address:_____

Phone Numbers: mobile:_____

work:_____

Emails:_____

_____

Occupation:_____

Marital Status (circle): single married divorced separated widowed

Emergency contact:_____

Please list Primary care physician, referring physician, and other relevant health care providers including phone numbers: _____

_____

_____

_____

Please list your Leisure activities:_____

_____

Please circle the best description of your current health: excellent, good, fair, poor

If you have been treated in the past 3 months, please describe for what reason (illness, medical condition, injury, etc), and the results of your care.

_____

_____

_____

Patient Medical History: have you ever been diagnosed with any below conditions

Allergies	Y / N	Dizzy Spells	Y / N	MRSA	Y / N
Anemia	Y / N	Emphysema/Bronchitis	Y / N	Multiple Sclerosis	Y / N
Anxiety	Y / N	Fibromyalgia	Y / N	Muscular Disorder	Y / N
Arthritis	Y / N	Fractures	Y / N	Osteoporosis	Y / N
Asthma	Y / N	Gallbladder Problems	Y / N	Parkinsons	Y / N
Autoimmune Disorder	Y / N	Headaches	Y / N	Rheumatiod Arthritis	Y / N
Cancer	Y / N	Hearing Impairment	Y / N	Seizures	Y / N
Cardiac Condition	Y / N	Hepatitis	Y / N	Smoking	Y / N
Cardiac Pacemaker	Y / N	High Cholesterol	Y / N	Speech Problems	Y / N
Chemical Dependency	Y / N	High/Low Blood Pressure	Y / N	Strokes	Y / N
Circulatory Problems	Y / N	HIV/AIDS	Y / N	Thyroid Disorder	Y / N
Currently Pregnant	Y / N	Incontinence	Y / N	Tuberculosis	Y / N
Depression	Y / N	Kidney Problems	Y / N	Vision Problems	Y / N
Diabetes	Y / N	Metal Implants	Y / N		Y / N

Using the space below list all surgeries, hospitalizations, medical procedures, and injuries that required treatment (including fractures, dislocations, illnesses, reconstructions, concussions, etc). Give approximate dates for each incident.

Please list any PRESCRIPTION medication and the dosage that you are currently taking.

Please circle any of the following over the counter medications that you are currently taking: Aspirin, Tylenol, Anti-inflammatories (Advil, Aleve, Motrin), Stomach medication (TUMS, Antacids), Vitamins, Minerals, Herbal remedies, Other:

_____

_____

In the past year I have fallen _____ times. If you did fall, were you injured? Y/N
How much caffeinated coffee, tea, or soda do you drink per day? _____
Do you smoke? Y/N If yes, for how long? _____
Do you drink alcohol? Y/N If yes, how much per day? _____
Please describe your diet and water intake: _____

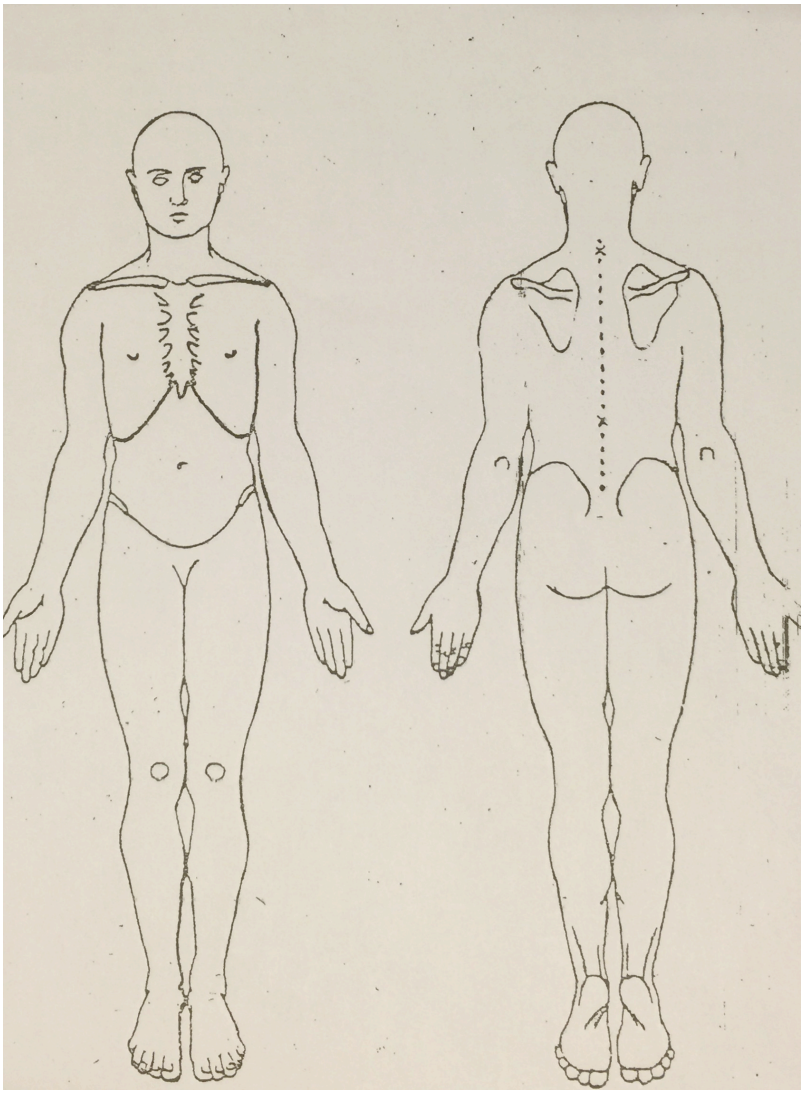
_____

Have you recently noticed any of the following:

weight loss/gain	nausea/vomiting	dizziness/lightheadedness	fatigue/weakness
fever/chills/sweats	numbness/tingling	tremors/seizures	loss or double vision
eye redness/dryness	skin rash	problems sleeping	sexual difficulties
night sweats	hearing problems	joint/muscle swelling	bruising/bleeding
difficulty breathing	regular cough	arm/leg swelling	heart racing in chest
difficulty swallowing	heartburn/indigestion	constipation/diarrhea	blood in stool/urine
post menopause	problems urinating	urinary incontinence	pregnancy
heightened stress	hormonal changes	pelvic pain	abdominal pain

This page is provided for you to describe and draw your symptoms. In other words, what brings you to seek treatment?

'////' Tingling 'xxxx' Pain 'oooo' numbness '++++' swelling



Pain levels: Current_____
Best_____Worst_____

To the best of my ability I have truthfully provided all above information as accurately as possible.

Printed name:_____Date:_____
Signature:_____ Date: _____
Witnessed:_____ Date: _____