PATIENT INTAKE FORM

Patient Name: _____ **Today's Date:**_____

Form Completed by: _____ **Relationship to client:**_____

What symptoms / problems bring you to therapy? _____

_____

Date above symptoms / problems were first noted: _____

Have you been treated for this problem before? Yes No

If yes, please explain: _____

Please check the following healthcare professionals that are involved in your medical care:

Primary Care	Physician's Name: _____
Pediatrician	Physician's Name: _____
Other:_____	Physician's Name: _____
Other: _____	Physician's Name: _____

Past Medical History: Have you ever had any of the following conditions? (check all that apply)

ADD/ADHD	Depression	Migraines
Anemia	Diabetes	Osteoporosis / Osteopenia
Anxiety	Difficulty Sleeping	Pacemaker
Arthritis	Dizziness	Psychological Conditions
Asthma	Falls/ Near Falls	Seizures
Blood Clot	Hearing Problems	Stroke
Breathing Difficultly	Heart Disease	Swallowing Problems
Brain Injury	Hepatitis	Tuberculosis
Broken Bones	Hypertension	Vision Problems
Cancer	Insomnia	Other: _____
Chemical Dependency	Learning Disability	_____
Circulation Problems	Mental Illness	_____

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Please list any surgeries or other conditions for which you have been *hospitalized,* including the approximate date and reason for the surgery or hospitalization:

Date	**Surgery / Reason for Hospitalization**
_____	_____
_____	_____
_____	_____

Are you currently taking any medications, vitamins, or supplements? Yes No

If you are attaching a medication sheet, check here:

If yes, please list all medications, dosage, and reason for taking each:

Medication / Vitamin / Supplement	Dosage	Reason for taking
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**please make sure to notify us of any changes in medications that may occur during your treatment with us.*

Please list any allergies: _____

For women, are you pregnant or think you might be pregnant? Yes No

Personal Information:

Do you have any cultural or ethnic needs which you want accommodated? Yes / No

Please Describe: _____

_____

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Educational / Employment Background:

Currently enrolled in school? Yes No

If yes, what school / grade? _____

Are you Currently Working? Yes No Retired

If yes, occupation: _____

If yes, do your present symptoms interfere with your ability to do your job? Yes No

If yes, please explain: _____

Do you or the patient have a concern for your safety from someone in your home or community? Yes No

Have you (patient) fallen in the past 3 months? Yes No

Do you have a concern that you (patient) may fall during daily activities? Yes No

Reviewed by:

_____

Clinic Staff Signature: **Date:**

Additional Information:

What do you hope to achieve with rehabilitation services? _____

_____

I confirm that all above information is correct to the best of my knowledge:

_____

Patient / Caregiver Signature: **Date:**

How did you hear about us?

- ☐ Word of mouth
- ☐ Referred by physician:
- ☐ Internet
- ☐ Inova Navigator Referral
- ☐ Insurance provider
- ☐ Emergency Dept
- ☐ Urgent Care Center
- ☐ Hospital Referral

We know you have a choice for your rehabilitation needs, thank you for choosing Inova.