Intake Form: Physical Therapy Led Health & Wellness Screen

Modified from APTA intake form

Demographics			
Name: _____	**Date form completed:** _____		
Address: _____	**City:** _____	**State:**___	**Zip:** _____
Phone number: _____	**Email address:** _____		
Date of birth: / /	**Age:** ____ **Sex** (at birth)**:** ☐ Female ☐ Male		
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐Widowed ☐ Domestic Partner **Do you have children?** ☐Yes ☐No How many? _____ **Are you currently or were you recently pregnant?** ☐Yes ☐No	**How would you prefer we address you?** _____ **Height:** feet inches **Weight:** lbs		
Ethnicity/race: ☐ Hispanic, Latino, or Spanish ☐ Black or African American ☐ American Indian or Alaska Native ☐ Chinese, Filipino, Asian Indian, Vietnamese, Korean, Japanese, or other Asian	☐White ☐ Native Hawaiian, Samoan, Chamorro, or other Pacific Islander ☐ Prefer to self-describe: _____ ☐ Prefer not to say		
Education Level (highest grade completed)**:** ☐ K-12 ☐ GED ☐ Vocational Degree ☐ Some college / technical school ☐ College graduate ☐ Graduate school / advanced degree	**Occupation/employment status:** **(check all that apply)** ☐ Student ☐ Full-time job ☐ Part-time job ☐ Unemployed ☐ Retired ☐ Disability Occupation: _____		
Enough food to eat: ☐ Yes ☐ No	**Adequate housing:** ☐ Yes ☐ No		
Access to healthcare: ☐ Insured ☐ Underinsured ☐ Uninsured			
Primary care healthcare provider: _____			
Do you regularly visit your primary care provider?	☐ Yes ☐ No		
Have you ever had any form of therapy in the past? (PT, OT, SLP, etc.)	☐ Yes ☐ No Reason: _____		
Emergency contact: _____	**Phone number:** _____		

Client Health and Wellness Goals

Relevant Medical History		
Do you have a current or past history of any of the following?		**Comments:**
Heart Conditions High blood pressure, heart attack, pacemaker, heart failure, anemia, other heart conditions	☐ Yes ☐ No	
Heart Surgery Heart transplant, cardiac catheterization, coronary artery bypass graft, coronary angioplasty	☐ Yes ☐ No	Date:
Muscle or bone conditions Osteoarthritis, rheumatoid arthritis, osteoporosis, fracture history	☐ Yes ☐ No	
Pulmonary conditions History of COVID, COPD, asthma, shortness of breath	☐ Yes ☐ No	
Neurological Conditions Parkinson's disease, Huntington's disease, Multiple Sclerosis, stroke, traumatic brain injury, concussions, seizures/epilepsy, altered sensation (hands, feet, etc.), balance or coordination issues	☐ Yes ☐ No	
Gastrointestinal Conditions Ulcers, Crohn's disease, ulcerative colitis, constipation, gas/stool leakage	☐ Yes ☐ No	
Liver conditions	☐ Yes ☐ No	
Kidney conditions	☐ Yes ☐ No	
Diabetes	☐ Yes ☐ No	
Thyroid issues	☐ Yes ☐ No	
Other chronic conditions Chronic pain, allergies (latex or other), sleep apnea	☐ Yes ☐ No	Specify:
Cancer history (self or family)	☐ Yes ☐ No	Type & Date:
Other surgical history	☐ Yes ☐ No	Type & Date:

In the past year, have you experienced any of the following symptoms? If yes, please provide details.		**Comments:**
Chest discomfort with exertion	☐ Yes ☐ No	
Unexpected shortness of breath	☐ Yes ☐ No	
Dizziness, fainting, or blackouts	☐ Yes ☐ No	
Ankle swelling	☐ Yes ☐ No	
Unpleasant awareness of forceful, rapid, or irregular heart rate	☐ Yes ☐ No	
Burning or cramping sensations in lower legs when walking a short distance	☐ Yes ☐ No	
Recent changes in bowel and/or bladder function	☐ Yes ☐ No	
Night sweats or night pain	☐ Yes ☐ No	
Recent unexplained weight loss	☐ Yes ☐ No	
Changes in vision	☐ Yes ☐ No	
Difficulty swallowing	☐ Yes ☐ No	

Current Health Habits

Exercise	
Have you been advised by a medical provider not to exercise?	☐ Yes ☐ No
Do you exercise regularly?	☐ Yes ☐ No
On average, how many days a week do you perform moderate to vigorous intensity physical activity/exercise where your heart is beating faster and your breathing is harder than normal (such as a brisk walk)?	**Days per week:**
On average, how many minutes do you engage in exercise at a moderate to vigorous level?	**Minutes per day:**
Do you participate in muscle-strengthening activities?	☐ Yes ☐ No
Tobacco / nicotine use	
Do you currently use any tobacco or nicotine products? This includes cigarettes, cigars, chewing tobacco, vaping, etc.	☐ Yes ☐ No
If you use tobacco or nicotine products, are you interested in quitting?	☐ Yes ☐ No
Alcohol use	
How many days per week do you drink beer, wine, or other alcoholic drinks? _____	
Diet	
How would you rate your diet?	☐ Good ☐ Fair ☐ Poor

Are you currently following a structured diet?	☐ Yes ☐ No
Are you interested in a consult to nutritional services?	☐ Yes ☐ No

Sleep
On average, how many hours do you sleep per night? _____ hours

Hearing		
Do you feel you have any hearing loss?		☐ Yes ☐ No
Do you wear Hearing Aid(s)?		☐ Yes ☐ No

Functional activity review	
Do you use any kind of assistive device (cane, walker, wheelchair, etc.)	☐ Yes ☐ No Device:_____
Do you have difficulty with any other daily activity dressing, bathing, toileting, eating, or getting in or out of a car?	☐ Yes ☐ No
Do you require help from another person to complete activities of daily living?	☐ Yes ☐ No
Have you fallen in the past year? If so, how many times? _____	☐ Yes ☐ No

Current Medications:

Other:
Have you attended the Walsh University Community Clinic before? If so, did you receive a referral? Did you utilize referral site services?
In addition to today's health and wellness screen, is there anything else you would like examined (time permitting)?

Signature: _____ Date: _____

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