Intake Form: Physical Therapy Led Health & Wellness Screen

Modified from APTA intake form

Demographics
If you do not feel comfortable providing any information, you may leave it incomplete.

Name: _____	**Date form completed:** _____
Preferred name (if different): _____	**City:** _____ **State:**___ **Zip:** _____
Address: _____	**Email address:** _____ **Phone number:** _____
Date of birth: / /	**Age:** _____
Sex (at birth)**:** ☐ Female ☐ Male	**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	**Occupation/employment status:** **(check all that apply)** ☐ Student ☐ Full-time job ☐ Part-time job ☐ Unemployed ☐ Retired ☐ Disability Occupation: _____ **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
Education Level (highest grade completed)**:** ☐K-12 ☐GED ☐Vocational Degree ☐Some college / technical school ☐College graduate ☐Graduate school / advanced degree	**Do you have:** **Adequate housing:** ☐ Yes ☐ No **Enough food to eat:** ☐ Yes ☐ No

Access to healthcare: ☐ Insured ☐ 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? If so, when and what for? (PT, OT, SLP, etc.)

Client Health and Wellness Goals

Relevant Medical History	
Do you have a current or past history of any of the following? If comments, add below.	
Heart Conditions High blood pressure, heart attack, pacemaker, heart failure, anemia, other heart conditions	☐ Yes ☐ No ☐ Family
Heart Surgery Heart transplant, cardiac catheterization, coronary artery bypass graft, coronary angioplasty	☐ Yes ☐ No ☐ Family
Muscle or bone conditions Osteoarthritis, rheumatoid arthritis, osteoporosis, fracture history	☐ Yes ☐ No ☐ Family
Pulmonary conditions History of COVID, COPD, asthma, shortness of breath	☐ Yes ☐ No ☐ Family
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 ☐ Family
Gastrointestinal Conditions Ulcers, Crohn's disease, ulcerative colitis, constipation, gas/stool leakage	☐ Yes ☐ No ☐ Family
Liver conditions	☐ Yes ☐ No ☐ Family
Kidney conditions	☐ Yes ☐ No ☐ Family
Diabetes	☐ Yes ☐ No ☐ Family
Thyroid issues	☐ Yes ☐ No ☐ Family
Other chronic conditions Ex. Chronic pain, sleep apnea	☐ Yes ☐ No ☐ Family
Cancer history	☐ Yes ☐ No ☐ Family
Other surgical history	

Allergies (latex or other)
If you answered yes to any of the above, please explain:

In the past year, have you experienced any of the following symptoms?	
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

If you answered yes to any of the above, please explain:

Have you seen a physician for any of the above conditions?

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 per week: _____	
On average, how many minutes per day: _____	
What kind of physical activity do you participate in? (ex. walking, yoga, weightlifting, yard work)	
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
How many packs per week? _____	
How many years have you smoked? _____	
Alcohol use	
How many days per week do you drink beer, wine, or other alcoholic drinks? _____	
How many drinks per week? _____	
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 yes, compared to last year, how would you rate your overall improvement in daily function (e.g., home activities, self-care, sleep, etc.) on a scale of 0-100%, 100% being completely independent? If you attended the Walsh University Community Clinic before, 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: _____