PATIENT INTAKE FORM

Patient Name: ___________________________ Preferred Name: ___________________________

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: ___________________________

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:

<table>
<thead>
<tr>
<th>Date</th>
<th>Surgery / Reason for Hospitalization</th>
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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:**

<table>
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<tr>
<th>Medication / Vitamin / Supplement</th>
<th>Dosage</th>
<th>Reason for taking</th>
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*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: __________________________________________________________________
________________________________________________________________________________
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
☐ Urgent Care Center
☐ Hospital Referral
☐ Emergency Dept

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