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 __________________________
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>
<thead>
<tr>
<th>Medication / Vitamin / Supplement</th>
<th>Dosage</th>
<th>Reason for taking</th>
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Current Height: ________________  Current Weight: ________________

*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
- □ Emergency Dept
- □ Urgent Care Center
- □ Hospital Referral

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