

# Health History Intake Form

## For your information

An accurate health history is important to ensure that it is safe for you to receive different forms of therapy. If your health status changes in the future, please let us know. All information gathered for this treatment is confidential except as required or allowed by law or except to facilitate diagnosis(assessment) or treatment. you will be asked to provide written authorization for release of any information.

<b>Is this injury due to a motor vehicle or work-related accident?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Chief Complaint</b>	
<b>General Health Status</b>	<input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
<b>Please indicate the conditions you are experiencing or have experienced.</b>	<p><b>Respiratory</b>  <input type="checkbox"/> Chronic cough   <input type="checkbox"/> Shortness of breath   <input type="checkbox"/> Bronchitis   <input type="checkbox"/> Asthma  <input type="checkbox"/> Emphysema   <input type="checkbox"/> Family History?</p> <p><b>Cardiovascular</b>  <input type="checkbox"/> High Blood Pressure   <input type="checkbox"/> Heart Attack  <input type="checkbox"/> Pacemaker or similar device  <input type="checkbox"/> Low Blood Pressure   <input type="checkbox"/> Phlebitis/varicose veins  <input type="checkbox"/> Heart disease   <input type="checkbox"/> CCHF   <input type="checkbox"/> Stroke/CVA   <input type="checkbox"/> Family History?</p> <p><b>Head/Neck</b>  <input type="checkbox"/> Vision problems   <input type="checkbox"/> Vision loss   <input type="checkbox"/> Ear problems   <input type="checkbox"/> Hearing loss  <input type="checkbox"/> Headaches/migraines</p> <p><b>Infections</b>  <input type="checkbox"/> Hepatitis   <input type="checkbox"/> Skin conditions   <input type="checkbox"/> Respiratory conditions   <input type="checkbox"/> HIV  <input type="checkbox"/> Herpes</p> <p><b>Other Conditions</b>  <input type="checkbox"/> Loss of sensation   <input type="checkbox"/> Diabetes   <input type="checkbox"/> Allergies   <input type="checkbox"/> Epilepsy   <input type="checkbox"/> Cancer  <input type="checkbox"/> Arthritis</p> <p><b>Women - Pregnant?</b>  <input type="checkbox"/> Yes   <input type="checkbox"/> No</p> <p><b>Soft Tissue/Joint Discomfort</b>  <input type="checkbox"/> Neck   <input type="checkbox"/> Upper Back   <input type="checkbox"/> Mid Back   <input type="checkbox"/> Low Back   <input type="checkbox"/> Shoulders  <input type="checkbox"/> Arms   <input type="checkbox"/> Legs   <input type="checkbox"/> Knees   <input type="checkbox"/> Other</p> <p><b>Other Medical Conditions?</b>  <input type="checkbox"/> YES</p>

<b>Medications</b>	
<b>Previous/Upcoming Surgeries</b>	
<b>Present involvement in other healthcare?</b>	<input type="checkbox"/> Physical Therapy <input type="checkbox"/> Massage Therapy <input type="checkbox"/> Chiropractor <input type="checkbox"/> Acupuncture <input type="checkbox"/> Osteopathy <input type="checkbox"/> Personal Trainer <input type="checkbox"/> Nutritionalist <input type="checkbox"/> Other

**Informed Consent**

I am aware of the fees for physical therapy assessment and treatment. I hereby consent to treatment by the attending therapist. All information in my file will be kept confidential, although the file will be shared among any treating therapists and/or practitioners in this clinic. I understand that written authorization will be obtained prior to any release of information, except when required by a court of law.

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*This template was adapted from a real intake form used by physical therapists on Jane. Customize it to reflect your practice's policies, branding, jurisdiction, and scope of practice.*