

# MoonWater Healing Center

## Physical Therapy Medical History Intake Form

Name: \_\_\_\_\_  
Address: Street: \_\_\_\_\_ City: \_\_\_\_\_  
State: \_\_\_\_\_ Zipcode: \_\_\_\_\_ Birth date: \_\_\_\_\_  
Phone: Home: \_\_\_\_\_ Work: \_\_\_\_\_  
Mobile: \_\_\_\_\_ Email: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Emergency Contact's phone number: \_\_\_\_\_

Has a doctor or health professional ever told you that you have or had any of the following conditions? Please check all that apply.

- |  |  |
|--|--|
| <input type="checkbox"/> Congenital heart defect                   | <input type="checkbox"/> Cancer                                    |
| <input type="checkbox"/> Heart problems/heart disease              | <input type="checkbox"/> Joint replacement/repair                  |
| <input type="checkbox"/> Joint, tendon or muscular pain            | <input type="checkbox"/> Gastrointestinal issues                   |
| <input type="checkbox"/> Osteoporosis                              | <input type="checkbox"/> Skin problems                             |
| <input type="checkbox"/> Pacemaker                                 | <input type="checkbox"/> Psychological                             |
| <input type="checkbox"/> High or low blood pressure                | <input type="checkbox"/> High or low blood sugar                   |
| <input type="checkbox"/> Chest pain/angina/palpitations            | <input type="checkbox"/> High cholesterol                          |
| <input type="checkbox"/> Abdominal pain/bloating/gas               | <input type="checkbox"/> Emphysema                                 |
| <input type="checkbox"/> Shortness of breath                       | <input type="checkbox"/> Poor balance or recent falls              |
| <input type="checkbox"/> Coughing/wheezing on exertion             | <input type="checkbox"/> Dizziness/vertigo/fainting/blackouts      |
| <input type="checkbox"/> Gout                                      | <input type="checkbox"/> Severe headaches                          |
| <input type="checkbox"/> Rheumatoid arthritis                      | <input type="checkbox"/> Prostate problems                         |
| <input type="checkbox"/> Anemia                                    | <input type="checkbox"/> Epilepsy/Seizure disorders                |
| <input type="checkbox"/> Ulcers                                    | <input type="checkbox"/> Circulation problems or blood clots       |
| <input type="checkbox"/> Depression                                | <input type="checkbox"/> Liver disease                             |
| <input type="checkbox"/> Kidney disease                            | <input type="checkbox"/> Sexually transmitted diseases or HIV/AIDS |
| <input type="checkbox"/> Tuberculosis                              | <input type="checkbox"/> Lung Disease                              |
| <input type="checkbox"/> Thyroid Problems                          | <input type="checkbox"/> Allergies                                 |
| <input type="checkbox"/> Asthma/bronchitis/pneumonia/chronic cough | <input type="checkbox"/> Diabetes                                  |
| <input type="checkbox"/> Stroke                                    | <input type="checkbox"/> Chemical dependency (i.e. alcoholism)     |
| <input type="checkbox"/> Latex allergy                             | <input type="checkbox"/> Lyme disease                              |
| <input type="checkbox"/> Hepatitis A,B,C                           | <input type="checkbox"/> Painful bowels/loose stool/constipation   |
| <input type="checkbox"/> Multiple sclerosis                        | <input type="checkbox"/> Other: _____                              |

Provide details regarding conditions checked above: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you under a doctor's care?  Yes  No If yes, please explain and give doctor's name:

Please list any other medical conditions you have: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Have you **recently** noted:

- Weight loss/gain       Nausea/vomiting     Weakness                       Numbness/tingling
- Fatigue                       Dizziness               Shortness of breath       Headaches
- Fever/chills/sweats     Pain at night               Difficulty swallowing     Change of appetite

Are you pregnant?     Yes     No    How much water do you drink a day? \_\_\_\_\_

How many cigarettes do you smoke a day? \_\_\_\_\_

How much coffee or caffeinated beverages do you drink a day? (ounces) \_\_\_\_\_

How many alcoholic beverages do you consume in one week? \_\_\_\_\_

Do you have any food cravings or intolerances? \_\_\_\_\_

Describe your typical meals of breakfast, lunch, dinner and snacks including times: \_\_\_\_\_

How is your energy? \_\_\_\_\_ What time of day is it highest? \_\_\_\_\_ Lowest? \_\_\_\_\_

How do you feel emotionally? \_\_\_\_\_

Do you have (check all that apply):  Depression  Anxiety  Panic attacks  Irritability or short temper  
 Poor memory  Difficult concentration  Other

Married/stable relationship     Single    How do you feel about your relationship? \_\_\_\_\_

How do you feel about your work? \_\_\_\_\_

How are your family relationships? \_\_\_\_\_

How / where do you hold stress? \_\_\_\_\_

How do you relax? \_\_\_\_\_

Describe your social outlets, leisure activities, and hobbies: \_\_\_\_\_

How many hours do you generally sleep per night? \_\_\_\_\_ Number of times you wake up \_\_\_\_\_

Do you have night sweats? \_\_\_\_\_ Do you have trouble  Falling asleep  Staying asleep  Disturbed sleep  
(Describe) \_\_\_\_\_

What forms of exercise do you practice and how often? \_\_\_\_\_

Accidents, injuries, or major illnesses including motor vehicle (include date): \_\_\_\_\_

Surgeries (include date): \_\_\_\_\_

Medications, vitamins, herbs, teas, over-the-counter medications and supplements (include dosage): \_\_\_\_\_

Family medical history: (Please list major illnesses in your close family such as diabetes, heart disease, high blood pressure, neurological disorders, psychological disorder, orthopedic disorders, etc.) \_\_\_\_\_

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What other practitioners are you currently seeing for this condition? (Please list all with the frequency, duration, and treatment involved) \_\_\_\_\_

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Describe what condition you are here to be treated for and how long you have had it (date of onset):

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Have you had any prior episodes for this condition? How many? \_\_\_\_\_

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Have you undergone any diagnostic testing:  Nerve Conduction Velocity  EMG  Bone Scan  MRI  
 Cardiac Stress Test  CT scan  Blood Test  Doppler Studies  Urinalysis  X-rays  
 Other: \_\_\_\_\_

Results from the above tests: \_\_\_\_\_

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Was the onset due to:  Injury at Home  Slow onset  Chronic  Work related  Repetitive motion  Sports  
 Recreational  Trauma  Unknown  Other: \_\_\_\_\_

Was the onset due to:  Backward bending  Forward bending  Twisting R or L  Crushing  Heavy lifting  
 Illness  Trauma  Overuse  Other: \_\_\_\_\_

What was the onset speed of your injury  Gradual  Sudden

Which of the following describes your symptom trend:  Improving  Unchanging  Worsening

For the following activities check the box that applies to your current symptoms:  
(Numbness=N, Pain= P, Stiffness=S)

**N P S**

- Arm/hand Activities
- Ascending Stairs
- Ballistic Activities
- Bending
- Climbing Ladders
- Computer Use
- Crawling
- Crouching
- Descending Stairs
- Driving
- Kneeling
- Lying on L Side
- Lying on R Side

**N P S**

- Lying on Back
- Overhead Activity
- Pinching/Grasping
- Quick Movements of Head/Neck
- Reaching
- Sitting
- Squatting
- Standing
- Walking
- Walking on Uneven Ground
- Work Activities
- Lying on Stomach

What is the frequency of your pain?  Constant  Intermittent/daily  Occasional (less than daily)  
 Sporadic (less than weekly)  More specifically \_\_\_\_\_

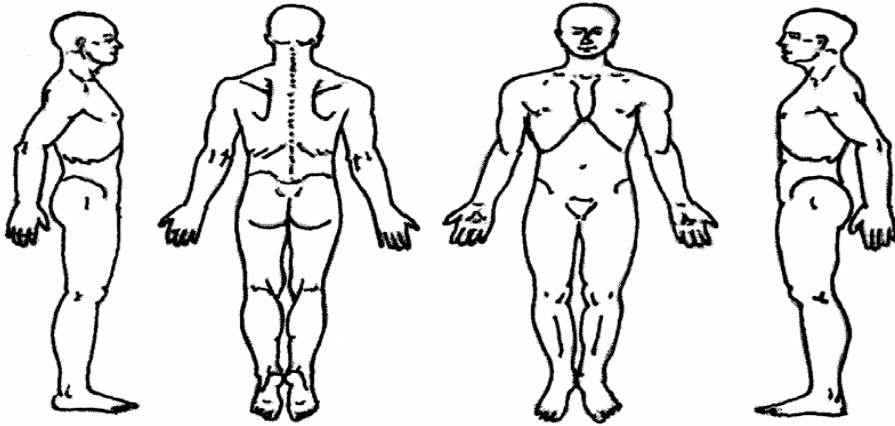
What is your pain intensity on average? (0= no pain, 10= worst imaginable) \_\_\_\_\_

At its worst \_\_\_\_\_ At its best \_\_\_\_\_ At rest \_\_\_\_\_

At night \_\_\_\_\_ With movement (please specify movements) \_\_\_\_\_

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Please indicate where your pain or symptoms are by shading areas below:



What specific remedies or movements decrease your pain? \_\_\_\_\_  
Does it radiate and if so where? \_\_\_\_\_  
Does your pain change morning to noon to evening? Describe: \_\_\_\_\_  
\_\_\_\_\_

What is the quality of your pain?  Sharp  Dull  Achy  Burning  Stabbing  Throbbing  Pulsating  
 Deep  Boring  Shooting  Searing  Radiating  Tearing  Gripping  Gnawing  Ripping  
 Other: \_\_\_\_\_

Do you have  Pins and needles  Numbness  Tingling  Loss of sensation  Hypersensitivity  
 Strength loss? If so, where? \_\_\_\_\_

Please indicate which activities you have difficulty or pain with:  Cooking  Dressing  Driving  
 House cleaning  Toileting  Other \_\_\_\_\_

Please indicate how long you can perform each activity before your pain gets worse:  
Walking \_\_\_\_\_ Standing \_\_\_\_\_ Sitting \_\_\_\_\_ Kneeling \_\_\_\_\_  
Running \_\_\_\_\_ Biking \_\_\_\_\_ Elliptical \_\_\_\_\_ Swimming \_\_\_\_\_  
Rowing \_\_\_\_\_ Lifting (pound capacity) \_\_\_\_\_ Driving \_\_\_\_\_  
Computer use \_\_\_\_\_ How many hours do you spend on the computer each day? \_\_\_\_\_  
Have you ever received an ergonomic workspace evaluation? \_\_\_\_\_  
What was your previous functional capacity and lifestyle before the injury or pain onset? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you seeking or planning to seek legal counsel for this condition? If yes, please provide name of attorney and details: \_\_\_\_\_  
\_\_\_\_\_

I certify that the above information is correct to the best of my knowledge. I have disclosed all medical conditions that I am aware of and will inform my practitioner of any changes in my health status. I understand that these services are a health aid and not a substitute for a doctor's care.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_