Intake Client Paperwork/Health History

Name____ Date of Birth____/_____/______

SEX: M F Home Address ____Apt #_______

City ____State_______ Zip ___________

Home Phone # (____)___________________Cell Phone # (____)______________________

Emergency Contact____ Relation____________________

Phone #______________________ Email ____

Primary insurance ______________________________ Phone #_____________________

Name on Card _____________________________ID #_________________________ Group #_________

Secondary insurance ____ Phone # ________________

Name on Card ___________________________________ ID #____________________ Group #_________

Referring MD and Specialty ____

Phone #_______________________Fax #________________________

Address ____

Dates of Hospitalization in past year ____

Dates of Home Health, under Medicare Part A in past year _________________________________

Prior Therapy received in past year ______________________________________

Current Medications:

Medical History	
1. High blood pressure 2. Diabetes 3. Cancer 4. Heart disease/ heart attack 5. Chest discomfort 6. Heart murmur/ valve disease 7. Shortness of breath 8. Swollen ankles 9. Palpitations 10. Lightheadedness / Dizziness 11. Rheumatic fever 12. Asthma 13. Persistent swollen glands 14. Hearing problems 15. Bone fractures 16. Depression	17. History of fall. How many episodes did you have in the past 12 month____? 18. Bronchitis 19. Pneumonia 20. Persistent cough 21. Tuberculosis 22. Hay fever 23. Sinusitis 24. Abdominal discomfort 25. Indigestion/heartburn 26. Nausea 27. Vomiting 28. Diarrhea 29. Blood in stool 30. Constipation 31. Vision problems 32. Other: i.e. Parkinson’s Disease, MS, ALS etc