BALANCE CHICAGO

Physical Therapy Intake Form

Name: _____ Date of Birth: ____/ ____/ _____ Height: ____Weight: ____

Referring Doctor: _____ Primary Care Physician: _____

What is your reason for seeking care? _____

How did you find Balance Chicago? _____

When did the problem begin? _____

What tests have you done for your current condition? _____

Have you seen a doctor or been hospitalized for your condition in the past year? ☐ **Yes** ☐ **No**

Have you had any surgeries? ☐ **Yes** ☐ **No** If yes, what & when? _____

Is your injury the result of a fall? ☐ **Yes** ☐ **No** Have you fallen in the last 12 months? ☐ **Yes** ☐ **No**
If yes, how many falls? _____

Is anyone coming into your home to help you? ☐ **Yes** ☐ **No** If yes, who? _____

Do you have pain/dizziness now? ☐ **Yes** ☐ **No**

What makes it better? _____

What makes it worse? _____

Please rate your pain/dizziness from 0-10 (0 = no pain/dizziness. 10 = extreme pain/dizziness)

_____/10 (Currently) _____ / 10 (Best) _____ / 10 (Worst)

Please check all symptoms/conditions you have had:

□ Allergies _____ □ Anxiety □ Arthritis □ Asthma □ Crohn's Disease □ Cancer: _____

□ Depression □ Diabetes □ Eating Disorder □ Fibromyalgia □ Hearing Problem □ Heart Disease

□ High Blood Pressure □ High Cholesterol □ HIV/AIDs □ Insomnia □ Joint Injuries □ Multiple Sclerosis

□ Osteoporosis □ Parkinson's □ Pacemaker □ Rheumatoid Arthritis □ Seizures □ Migraines

□ Sleep Apnea □ Stroke □ Vision Problems □ Irritable Bowel Syndrome □ Other _____

Medication List - Please Indicate Dosage:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Additional Questions:

Were you involved in any car accidents? □ **Yes** □ **No** _____
Did you have any serious falls/injuries as a child? □ **Yes** □ **No** _____
Do you drink alcohol? □ **Yes** □ **No** _____
Do you smoke cigarettes? □ **Yes** □ **No** _____
Do/did you take/use recreational drugs? □ **Yes** □ **No** _____
Is this a legal/workman's comp care? □ **Yes** □ **No** _____