Integrative Physical Therapy Nutrition & Wellness

Assessment

General Health Intake

Name:____
Date:______________________

Age: ______ Date of Birth:_______

Height:_________ Weight:__________Marital Status__________

Occupation:____

What is your desire for your weight?____

Email address:____

Are you currently under the care of an MD, DO, chiropractor or other health professional for any reason?____
Treating Physician's Name and phone number:____

Date of most recent physical exam:______________________________

If it is relevant, may I obtain a copy of the most recent test results?____

Current Health Concerns: Be as specific as possible

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Do you currently have, or have you been treated for any of the following Symptoms/ conditions? ***Please Check (√)ALL that apply:***

__ Abdominal Pain

—Allergies (specify)____

—Anxiety

—Arthritis (osteoarthritis, rheumatoid or other)

—Asthma

—Attention Deficit disorder

__Autoimmune Disorder: List:_____________________________

—Bladder issues including UTI

—Blood clots or clotting disorders

—Bloating, Gas, belching, cramping

—Cancer (specify)________________________________

—Cardiac condition (heart attack, angina, valve disorder, arrhythmia, congestive heart failure, pacemaker)

—Celiac disease, Food Intolerances or allergies

—Constipation or recent change in bowel habits

—Cough or Bronchitis; Shortness of breath

—Depression

—Diabetes or High blood sugar

—Diarrhea

—Frequent colds or infections

—Gout

—Heart burn/Acid Reflux disease (GERD)

—High blood pressure

—High cholesterol, elevated triglycerides

—Insomnia

—Kidney disease or Kidney stones

—Liver disease or Hepatitis

—Low Blood sugar (Hypoglycemia)

—Nausea/Vomiting

—Neck or Back pain, recurring or chronic

—Obesity or inability to lose weight

—Osteoporosis or a recent fracture

—Rashes, eczema: explain:_________________________________

—Stroke or TIA

—Thyroid Condition: Type_________________________________

—Ulcerative colitis or Irritable Bowel syndrome

Please list any other health issues not mentioned above, including surgeries:____

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List all current medications, including vitamins, supplements, herbal formulas (prescription or over the counter) that you are taking, and dosages:____

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