Aspire PT & Wellness, LLC Intake Form

Today's Date: _______________

Name: ____________________________________ Occupation: ____________________________ Age: _____

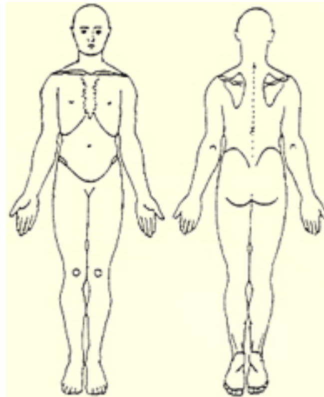
Physician:____________________________ Specialty: ____________________ Date of last Physical: _______

Date of Onset: Injury/Pain/Surgery: ____

Briefly state previous treatment, if any: ____

____

Please mark your current area(s) of symptoms on the body chart below and briefly describe (sharp, dull, tingling, numb, achy, etc…)



Please circle and explain if you currently have, or have had in the past, any of the below.

Heart condition	Migraine or frequent headaches
Heart attack	Cervical problems (neck)
High Blood Pressure	Lumbar problems (low back)
Circulation Problems	Thoracic problems (mid back)
Stroke	SIJ problems (sacroiliac)
Cancer	Pelvic problems
Diabetes	Shoulder, elbow or wrist problems
Peripheral Vascular Disease	Hip, knee or ankle problems
Shortness of Breath	Scoliosis
Glaucoma	Osteoarthritis
Neurological Disease (MS, Parkinsons…)	Rheumatoid Arthritis
Respiratory Disease (asthma, emphysema, bronchitis)	Fractures/dislocations
Hernia	Osteoporosis/Osteopenia
Reflux	Concussion: how many? When?
Pregnancy: how many? Births?	Other:
Depression: Anxiety:	Other:

Please list any injuries, surgeries and/or hospitalizations and their dates of treatment:

____

____

OTC Medication: please circle any of the medications that you have taken in the past week:
Anti-inflammatories (Advil, Aleve, Motrin) Aspirin Tylenol Anti-histamines Vitamins Other: ________________

Prescription Medication: Please list any prescription medication you are currently taking:

____

How many times per week do you participate in sports/recreational activities? _______

How many hours? ________

Please list the sports/recreational activities you participate in and how often:

____

Have you *recently* experienced: (please circle all that apply)

Weight Gain/Loss	Night Pain	Bowel or Bladder Incontinence
Nausea/Vomiting	Difficulty Breathing	Constipation/Diarrhea
Dizziness/Lightheadedness	Coughing	Difficulties Urinating
Fatigue	Tremors	Blood in Stools
Weakness	Change in Vision	Stress/Depression/Anxiety
Fever/Chills/Sweats	Joint Swelling	Sensitivity to Light/Noise
Numbness or Tingling	Arm/Leg Swelling	Difficulties with Memory

Immediate Family Medical History: Only circle if parent, sibling or child has had any of the following:

Heart Disease	High Blood Pressure	Stroke
Cancer	Diabetes	Inflammatory Disease
Depression	Depression	

Are you pregnant or think you may be pregnant? Yes No

Daily Caffeine Intake (include coffee, tea and soda): _____________

Do you smoke, have you ever smoked, or used tobacco? Yes No **How much?** __________ **How long?** ______

Alcohol consumption: How many glasses per week? ______ **On average, how many glasses per sitting?** _____

Signature of Patient ____ Date _________________