

INITIAL EVALUATION INTAKE FORM

- 1) Name: _____
Last First Middle
- 2) Date of Birth: ____/____/____
Month Day Year
- 3) Sex: ___ Male ___ Female
- 4) Are you: ___ Right-handed ___ Left-handed

SOCIAL HISTORY

- 5) Cultural/Religions: Any customs or religious beliefs or wishes that might affect care?

- 6) With whom do you live?
 ___ Alone
 ___ Spouse only
 ___ Spouse and children (# of children: ___) Ages of children living at home: _____
 ___ Children only (# of children: ___) Ages of children living at home: _____
 ___ Other relatives (not spouse or children)
 ___ Group setting
 ___ Personal care attendant
 ___ Other

- 7) Who referred you to us?
 ___ Physician ___ Physical Therapist ___ Claims Manager
 ___ Insurance Co. ___ Attorney ___ Yoga Instructor
 ___ Pilates Instructor ___ Personal Trainer ___ Other: _____

- 8) Employment/School:
 ___ Working full-time outside of home ___ Working part-time outside of home
 ___ Working full-time from home ___ Working part-time from home
 ___ Homemaker ___ Student ___ Retired ___ Unemployed
 Occupation: _____

SOCIAL/HEALTH HABITS

9) Smoking:

Do you currently smoke tobacco? Yes No
 If yes, how many packs per day? One More than one
 If you smoke cigars/pipes, how many? One a day More than one a day
 Have you smoked in the past? Yes No Year quit: _____

10) Alcohol:

How many days per week do you drink beer, wine, or other alcoholic beverages on average? 0 1 2 3 4 5 6+
 If one beer, one glass of wine, or one cocktail equals one drink, how many drinks do you have on an average day? N/A 1 More than 1

11) Exercise:

Do you exercise beyond normal activities and chores? Yes No
 If yes, describe your exercise: _____
 On average, how many days per week do you exercise or do physical activities?
 1 2 3 4 5 6 7
 For how many minutes, on average? <20 20 30 40 >40

LIVING ENVIRONMENT

12) Does your home have...?

Stairs (no railing) Stairs (with railing) Ramps
 Elevator Uneven terrain Assistive devices (e.g., bathroom)
 Other obstacles: _____ Other: _____

13) Do you use...?

Cane Walker Motorized wheelchair Manual wheelchair
 Glasses Hearing aid Other: _____

14) Where do you live?

Private home/condo Private apartment Other: _____

GENERAL HEALTH STATUS

15) Please rate your health:

Excellent Good Fair Poor

16) Have you had any major life changes during the past year? (e.g., new baby, job change, death of a family member, etc.): ___ Yes ___ No

MEDICAL/SURGICAL HISTORY

17) Please check if you have ever had:

- | | | |
|--|--|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Broken bones/fractures |
| <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Blood disorders | <input type="checkbox"/> Muscular dystrophy |
| <input type="checkbox"/> Parkinson disease | <input type="checkbox"/> Seizures/epilepsy | <input type="checkbox"/> Circulation/vascular problems |
| <input type="checkbox"/> Development or growth problems | <input type="checkbox"/> Heart problems | |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Cancer | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Stroke | <input type="checkbox"/> Lung problems |
| <input type="checkbox"/> Infectious disease (e.g., HIV, tuberculosis, hepatitis) | | |
| <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Head injury | <input type="checkbox"/> Diabetes/high blood sugar |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Skin diseases | <input type="checkbox"/> Low blood sugar/hypoglycemia |
| <input type="checkbox"/> Repeated infections | | <input type="checkbox"/> Ulcer/stomach problems |
| <input type="checkbox"/> Other: _____ | | |

18) Within the past year, have you had any of the following symptoms?

- | | | |
|---|---|---|
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Cough | <input type="checkbox"/> Difficulty sleeping |
| <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> loss of appetite | <input type="checkbox"/> Nausea/vomiting |
| <input type="checkbox"/> Bowel problems | <input type="checkbox"/> Weight loss/gain | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Urinary problems | <input type="checkbox"/> Fever/chills | <input type="checkbox"/> Dizziness or blackouts |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Coordination problems |
| <input type="checkbox"/> Hearing problems | <input type="checkbox"/> Difficulty walking | <input type="checkbox"/> Weakness in arms/legs |
| <input type="checkbox"/> Vision problems | <input type="checkbox"/> Pain at night | <input type="checkbox"/> Joint pain or swelling |
| <input type="checkbox"/> Other: _____ | | |

19) Please list any surgeries you've had:

20) Please list any medications you are currently taking:

