

Westside Dance Physical Therapy - Medical Intake Forms

Name: _____ Date: _____
Diagnosis: _____ MD: _____
Date of Birth: _____ Age: _____ Height: _____ Weight: _____
Occupation: _____
Emergency contact person: name _____
Phone: _____ Relationship to you _____

History of Present Injury

Date of Injury (if applicable): _____
Describe injury and how it occurred (positions, symptoms, etc.) _____

Place of Occurrence _____
Precipitating factors (eg. not warmed up, cold studio, hard floor) _____

Prior treatment (MD, Chiro, physical therapy, acupuncture, massage) _____

Assistive devices used (cane, crutch, brace, orthotics) _____

Medical tests performed and result (x-ray, MRI, CT scan, bone scan, blood tests, etc)

Please include: when? body region? results?

Personal Health Information:

Are you in good general health? _____

List any surgeries (date and procedure): _____

List prescription and over the counter medications: _____

Do you now or have you ever smoked? (specify packs per day/ how long) _____

Alcohol? (specify) _____ Caffeine? (specify) _____

Do you have a pacemaker, transplanted organ or metal implant? Yes / No

(describe) _____

Have any of the following symptoms occurred with your problem: (circle) numbness,

tingling, vomiting, loss of appetite, unexpected weight gain or loss, diarrhea,

constipation, blood in stool or urine, inability to hold or release urine, night sweats,

fevers, chills, vision changes, fatigue, weakness, headaches, dizziness, fainting spells

Are you currently under the treatment of any doctor other than your referring doctor?

Y/N If yes, who is the doctor and what is being treated? _____

List current fitness activities you do regularly: _____

What are your goals for physical therapy? _____

Past Medical History:

Have you or any immediate family member ever been told you have:

Circle one:	<u>YOU</u>	<u>FAMILY</u>
Cancer	Yes No -----	Yes No
Diabetes	Yes No -----	Yes No
Hypoglycemia	Yes No -----	Yes No
Hypertension or high blood pressure	Yes No -----	Yes No
Heart disease	Yes No -----	Yes No
Angina or chest pain	Yes No -----	Yes No
Shortness of breath	Yes No -----	Yes No
Stroke	Yes No -----	Yes No
Kidney disease/stones	Yes No -----	Yes No
Urinary tract infection	Yes No -----	Yes No
Allergies	Yes No -----	Yes No
Asthma, hay fever	Yes No -----	Yes No
Rheumatic/scarlet fever	Yes No -----	Yes No
Hepatitis/jaundice	Yes No -----	Yes No
Cirrhosis/liver disease	Yes No -----	Yes No
Polio	Yes No -----	Yes No
Chronic bronchitis	Yes No -----	Yes No
Pneumonia	Yes No -----	Yes No
Emphysema	Yes No -----	Yes No
Migraine headaches	Yes No -----	Yes No
Anemia	Yes No -----	Yes No
Ulcers/stomach problems	Yes No -----	Yes No
Arthritis/gout	Yes No -----	Yes No
AIDS/HIV-positive	Yes No -----	Yes No
Hemophilia/slow healing	Yes No -----	Yes No
Guillain-Barre syndrome	Yes No -----	Yes No
Epilepsy	Yes No -----	Yes No
Thyroid problems	Yes No -----	Yes No
Multiple sclerosis	Yes No -----	Yes No
Tuberculosis	Yes No -----	Yes No
Fibromyalgia/myofascial Pain syndrome	Yes No -----	Yes No
Lyme Disease	Yes No -----	Yes No
Lymph node removal	Yes No -----	Yes No
Alcoholism	Yes No -----	Yes No
Seizures	Yes No -----	Yes No
Osteoarthritis	Yes No -----	Yes No
Other (please describe)	Yes No -----	Yes No

Special Questions for Dancers (for dance professionals or those with dance injuries)

Age began dancing _____ Type of dance you do: _____

Age you began pointe work: _____

Formal dance training: school _____ number of years _____

school _____ number of years _____

Present dance training and number of classes/week: _____

Are you performing now? _____ Name of Company: _____

Type of shoes worn: _____ Type of floor surface you dance on: _____

Number of years you have been dancing as a professional: _____

List major injuries of illnesses throughout your career including:

Date	Type of injury	Whom seen	Course of Treatment	Recovery

Special Questions for Women

- At what age did you start menstruating? _____
- Are your cycles regular? _____ yes/no _____
Explain: _____
- Are the symptoms of your CURRENT INJURY associated with your menstrual cycle either around the 14th day (ovulation) or at the onset of menses? __ Yes/No
- Do you notice a change in flexibility at either of these times? Yes/No _____
- Circle any premenstrual symptoms: water retention, mood swings, headaches, food cravings, tender breasts, other _____
- What type of birth control do you use? _____
- Pregnancies: _____ Vaginal births _____ Cesarean section _____
Episeotomy _____ Numbness in pelvic area? _____
Problems related to pregnancy _____
- Do you currently experience leakage of urine? Yes/No Circle if it occurs with Jumping, Coughing, Sneezing, Laughing, Intercourse, When putting key in door
- Do you have any pelvic pain? Yes/No What activity brings it on? _____
- Circle if you have had or have any of the following: Retroverted uterus, Fibroids or tumors, Endometriosis, Ovarian cyst, Pelvic inflammatory disease, Osteopenia, Osteoporosis, Diabetes,
- Have you gone through menopause Yes/No or perimenopause Yes/No
- Are you taking any medications, herbs or supplements for hormone replacement? Yes/No If yes, please list _____

