The Lifestyle Athlete PLC
South Burlington Physical Therapy

Health Intake

Briefly describe why you are here today: _____

When did the problem begin? _____ Have you had the problem before? _____

What are your goals for physical therapy? _____

Do you exercise? If yes, how often and what type: _____

Allergies: _____
Are you allergic to (circle): Latex Bees Sulfa Nuts

Are you currently pregnant: Yes No **If Yes, when are you due?** _____

Number of previous pregnancies: _____

What year(s) *and* type(s) of delivery: _____

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

Chest Pain	Loss of balance	Unexpected weight loss/gain
Heart Palpitations	Difficulty walking	Fever/chills/sweats
Cough	Joint pain/swelling	Headaches
Hoarseness	Pain at night	Hearing problems
Shortness of breath	Difficulty sleeping	Vision problems
Dizziness or blackouts	Loss of appetite	Involuntary urine leakage
Coordination problems	Nausea/vomiting	Bowel problems
Weakness in arms/legs	Difficulty swallowing	Other: _____

During the past month, have you felt depressed or sad? Yes No

Please check all practitioners for which you've sought care for your current condition:

[ ] Medical Doctor	[ ] Dentist	[ ] Chiropractor	[ ] Other:
[ ] Osteopath	[ ] Physical Therapist	[ ] Massage Therapist	_____

When was your last appointment with that provider? _____

Patient Signature: _____ **Date:** _____

Is there anything else that you feel we should know to assist us with your treatment? _____

_____