HOMEPHYSIO
MELBOURNE

INTAKE FORM

Name: _____ Date: _____

Referred by_____ Height_____ Weight _____

Date of birth_____ Occupation: _____

Do you live alone? ❑ Yes ❑ No

If no, who do you live with:_____

Does your home have:

❑ Stairs, no railing ❑ Stairs, w/railing

❑ Ramps ❑ Elevator ❑ Uneven Terrain

❑ Other: _____

GENERAL HEALTH

Do you use:

❑ Cane ❑ Walker or rollator

❑ Manual Wheelchair ❑ Motorized wheelchair

❑ Other_____

Please rate your health:

❑ Excellent ❑ Good ❑ Fair ❑ Poor

HEALTH HABITS

Do you exercise regularly? ❑ Yes ❑ No

If yes, how often and what type of activities?

_____

_____

_____

_____

FAMILY HISTORY

(Indicate whether mother, father, brother/sister, aunt/uncle, or grandmother/grandfather had any of the following disorders and provide age of onset if known)

Heart disease: _____

Hypertension: _____

Stroke: _____

Diabetes: _____

Cancer:_____

Other: _____

MEDICATIONS

Do you take any prescription medications?

❑ Yes ❑ No

If yes, please list:

_____

_____

_____

_____

_____

PAST MEDICAL HISTORY

Please check if you have ever had:

❑ High blood pressure
❑ Arthritis
❑ Blood disorders
❑ Broken bones
❑ Cancer
❑ Vascular problem
❑ Depression
❑ Infectious disease (such as tuberculosis, hepatitis)
❑ Kidney problems
❑ Low blood sugar
❑ Lung problems
❑ Multiple sclerosis
❑ Osteoporosis
❑ Developmental problems
❑ Diabetes
❑ Stroke
❑ Thyroid problems
❑ Parkinson's diseases
❑ Seizures/epilepsy
❑ Heart problems
❑ Allergies (list)

_____

_____

_____

_____

_____

_____

_____

CONTINUED ON OTHER SIDE

CURRENT LIMITATION (CHECK ALL THAT APPLY)

- ❑ Difficulty with bed mobility
- ❑ Difficulty with transfers (such as moving from bed to chair, from bed to commode)
- ❑ Difficulty walking on level surface
- ❑ Difficulty walking on stairs
- ❑ Difficulty walking on ramps
- ❑ Difficulty walking on uneven terrain
- ❑ Difficulty with self-care (such as bathing, dressing, eating, toileting)
- ❑ Difficulty with household chores, shopping, driving
- ❑ Difficulty with community and work activities
- ❑ Difficulty work/ school
- ❑ Difficulty recreation or play activity

HISTORY OF CURRENT PROBLEM(S)

When did the problem(s) begin?
____/____/____

What occurred?

Have you ever had the problem(s) before?
❑ Yes ❑ No

What did you do for the problem(s)?

Did the problem(s) get better? ❑ Yes ❑ No

About how long did the problem last?

What makes the problem better?

What makes the problem worse?

What activities are you not able to do now that you could do before the problem(s)?
(Please be as specific as you can; for instance "Unable to reach over my head")

Rate the level of your pain on the following scale.

AT PRESENT:
1 2 3 4 5 6 7 8 9 10

AT BEST:
1 2 3 4 5 6 7 8 9 10

AT WORST:
1 2 3 4 5 6 7 8 9 10

Please draw pain on body chart

Pain description:
❑ Sharp ❑ Dull ❑ Burning ❑ Aching
❑ Tingling ❑ Numbness

+ = numbness 0 = pins/needles