

GENESYS

THERAPY SERVICES

PATIENT INTAKE/MEDICAL HISTORY

Name:	Today's date:		
Date of Birth:	Are you allergic to latex?	Yes	No
Age:	Do you smoke?	Yes	No
Occupation:	If female, are you pregnant?	Yes	No
Currently working? Yes No Restrictions?	(If yes, number of weeks?)	_____ weeks	
Sex: Male/Female Height: _____ Weight: _____	Hand Dominance:	Right	Left
Date of injury:	Prior Therapy for this condition?	Yes	No

Description of injury and how it happened:

Medications you are currently taking:

Surgical History (List all Surgeries)

Date of Surgery

Medical History: *check all that apply*

- | | | |
|--|--|---|
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Amputation | <input type="checkbox"/> Carpal tunnel |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Vision/hearing impairment | <input type="checkbox"/> Multiple sclerosis |
| <input type="checkbox"/> Heart problems | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Asthma | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Episodes of falling* |

What are the goals that you would like to achieve in therapy?

******* Below To Be Completed By Your Therapist *******

Diagnostic Testing: _____

****Is this patient over 65 years of age?*** Yes No

****Has patient indicated episodes of falling?*** Yes No

****Will therapy program consist of fall prevention activities?*** Yes No N/A