Clinical Intake

BeneFIT Physical Therapy
BRIDGEWATER NJ 908.203.5200
CHESTER NJ 908.879.5700
BeneFITpt.com

Patient Name: Last: ______________________ First: ____________________ MI: ________

Date of Birth: ____________________ Gender: ☐ Male ☐ Female

FAMILY HEALTH HISTORY Please Indicate if an Immediate Family Member (Parent, Sibling, Grandparent, Aunt/Uncle) Has Had Any of The Following:

Heart Disease: ______________________ Hypertension: ______________________
Stroke: ______________________ Diabetes: ______________________
Cancer: ______________________ Autoimmune Disease: ______________________
Osteoporosis: ______________________ Behavioral Health: ______________________
Other: ____

GENERAL HEALTH Height: __________ Weight: __________

How is Your General health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do You Perform Regular Exercise?: ☐ Yes ☐ No
If Yes, Approximate Duration Each Workout: __________ Number of Days per Week: __________
How Intense Are Your Workouts: ☐ Light ☐ Moderate ☐ Strenuous

Past Medical History To The Best of Your Knowledge Do You Have or Ever Have Had:

☐ Alzheimer's Disease/Dementia
☐ Anemia/Blood Disorder__________________
☐ Anxiety/Panic Attacks
☐ Arthritis/Osteoarthritis/Joint Pain
☐ Artificial Joints
☐ Asthma
☐ Autoimmune Disease__________________
☐ Benign Tumor/Growth
☐ Cancer__________________
☐ Cardiac Pacemaker
☐ Cerebral Palsy
☐ Chemical Dependency
☐ Chronic Headaches/Migraines
☐ Chronic Fatigue Syndrome
☐ Chronic Swelling of Extremities
☐ Circulation/Vascular Problems__________________
☐ Cognitive/Memory Loss
☐ Concussion
☐ Depression
☐ Diabetes/Blood Sugar Issue (High/Low)
☐ Dizziness/Lightheadedness/Vertigo
☐ Emphyzema/COPD/Chronic Bronchitis
☐ Fainting Disorders__________________
☐ Fractures (Area/Year) __________________
____
____

☐ Gallbladder Problems
☐ Gynecological Disorders
☐ Heart Attack/Chest Pains/Angina
☐ Hepatitis
☐ Hypertension/High Blood Pressure
☐ High Cholesterol
☐ HIV
☐ History of Smoking
☐ Incontinence (Bowel/Bladder)
☐ Kidney Disease/Stones__________________
☐ Lung Problems/Shortness of Breath
☐ Lyme's Disease
☐ Metal/Surgical Implants
☐ Multiple Sclerosis
☐ Osteoporosis/Osteopenia
☐ Parkinson's Disease
☐ Pregnant (currently)
☐ Peripheral Neuropathy
☐ Polio/Muscle Disease
☐ Seizures/Epilepsy
☐ Sleep Disorders/Sleep Apnea
☐ Speech Problems
☐ Stroke
☐ Thyroid Disease
☐ Tuberculosis
☐ Other__________________________

☐ **None of the Above**

Past Surgical History Please List Any Surgeries and The Approximate Date:

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Within the Past Year, Have You Had Any of These Symptoms? (Check All That Apply)

- ☐ Bowel Problems
- ☐ Chest Pain
- ☐ Cough
- ☐ Coordination Problems
- ☐ Difficulty Sleeping
- ☐ Difficulty Swallowing
- ☐ Difficulty Walking
- ☐ Difficulty Writing
- ☐ Dizziness/Blackouts
- ☐ Fever/Chills/Sweats
- ☐ Headaches
- ☐ Heart Palpitations
- ☐ Hearing Problems
- ☐ Hoarseness
- ☐ Joint Pain/Swelling
- ☐ Loss of Appetite
- ☐ Loss of Balance
- ☐ Nausea/Vomiting
- ☐ Pain at Night
- ☐ Repeated Falls
- ☐ Sensation Loss/Numbness
- ☐ Shortness of Breath
- ☐ Stabbing Pains
- ☐ Urinary Problems
- ☐ Unexplained Weight Loss/Gain
- ☐ Vision Problems
- ☐ Weakness in Arms or Legs
- ☐ Other______________________

☐ **None of The Above**

Within the Past Year, Have You Had Any of These Tests? (Check All That Apply)

- ☐ Angiogram
- ☐ Arthroscopy
- ☐ Bone Scan
- ☐ CT Scan
- ☐ EKG
- ☐ EMG
- ☐ MRI
- ☐ Myelogram
- ☐ NCV (Nerve Conduction Velocity)
- ☐ Stress Test
- ☐ X-Rays
- ☐ Other______________________

☐ **None of the Above**

Current Medications, Supplements, and Vitamins: (Name, Dose(mg), Times/Day)

______________________________ ______________________________
______________________________ ______________________________
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Description of Current Injury:

Current Diagnosis (If Any): ______________________________
Area Injured: ______________________________
Injury Date: ______________________ Surgery Date (If Any): ______________________
Involved Side: ☐ Right ☐ Left ☐ N/A Dominant Side: ☐ Right ☐ Left

Brief Description of Problem: ______________________________
Severity of Problem: ☐ Very Minor ☐ Minor ☐ Moderate ☐ Severe ☐ Very Severe
Is the Problem Getting: ☐ Much Worse ☐ A Little Worse ☐ No Change ☐ A Little Better ☐ Much Better
Any Current/Past Treatment for this Problem? ______________________________
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What Are Your Goals for Physical Therapy? ______________________________
____

Patient Signature: ______________________________ **Date**: ____________________
(Parent or Guardian if Patient is a Minor)