Natalie Dowty, PT, MPT, EdD
integrative wellness, inc., physical therapy & consulting
68th and Grover, Omaha, NE, 68106 • integrativewellnesspt.com
(402) 212-7444

Medical History / Intake Form

Patient Information

Name_____ Date_____
Email_____ Cell Phone_____
Home Phone_____ Work Phone_____
Street Address_____
City _____ State _____ Zip _____
Age_____ DOB_____ Occupation_____
Name of party responsible for payment_____ Relation to Patient_____
Emergency Contact(s)_____Relation to Patient_____
Emergency Contact Phone #s_____
Who referred you? / How did you learn about Integrative Wellness? _____

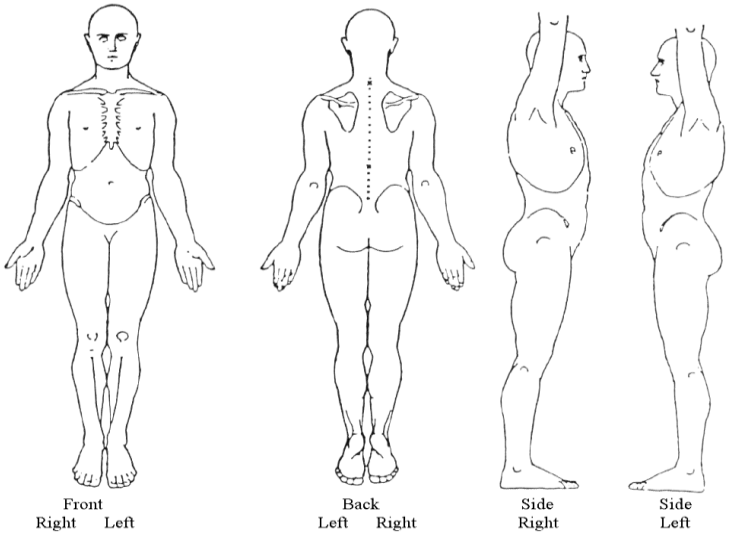
Current Complaint(s)

Briefly describe why you are seeking services. _____
_____
_____
Date that your symptoms started: _____ Are your symptoms work related? Yes____ No____
Are your symptoms related to an accident? Yes____ No____ Date of accident: _____
How, specifically, did your symptoms start? _____
_____

Rate your symptoms (0 = no symptoms, 10 = absolute worst possible). Circle the # that applies.

On the average/most of the time:	0	1	2	3	4	5	6	7	8	9	10
At it's worst:	0	1	2	3	4	5	6	7	8	9	10
At it's best:	0	1	2	3	4	5	6	7	8	9	10
Goal range:	0	1	2	3	4	5	6	7	8	9	10

On the body diagram, please mark areas of your symptoms as they are at the time of your visit with an X or using a number from the 0-10 scale above.



What makes your symptoms worse? _____
What makes your symptoms better? _____
List any doctors you have seen for this condition: _____
_____
Are you pregnant? Yes ____ No ____

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What treatment have you received for this issue?_____

Chiropractic/Osteopathic manipulation	Yes ___ No ___	Helpful? Yes ___ No ___
Trigger Point injections	Yes ___ No ___	Helpful? Yes ___ No ___
Epidural injections	Yes ___ No ___	Helpful? Yes ___ No ___
Physical Therapy	Yes ___ No ___	Helpful? Yes ___ No ___
Medications	Yes ___ No ___	Helpful? Yes ___ No ___
Acupuncture	Yes ___ No ___	Helpful? Yes ___ No ___
Other _____	Yes ___ No ___	Helpful? Yes ___ No ___

Medical History - Please submit separate typed or printed list(s) if necessary.

List any conditions for which you are currently being treated. _____

_____

List any chronic or past conditions. _____

_____

List any surgeries or traumatic injuries. _____

_____

List any allergies including drug or food allergies. _____

_____

How do you sleep? _____ How many hours? _____ How many interruptions? _____

Have you fallen in the last year? Yes ____ No ____ How many times? ____ Were you injured? Yes ___ No ____

List medication you are taking & the condition for which you are taking it. Include supplements.

Medication: _____ Condition: _____

Medication: _____ Condition: _____

Medication: _____ Condition: _____

Medication: _____ Condition: _____

Do you have, or have you had: (please check if yes)

- ☐ Addiction
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis (Osteo)
- ☐ Asthma
- ☐ Cancer
- ☐ Chest Pain
- ☐ Chronic Bronchitis
- ☐ COPD / Emphysema
- ☐ Cortisone Drug
- ☐ Depression
- ☐ Diabetes
- ☐ Diabetic Ulcer
- ☐ Epilepsy
- ☐ Fibromyalgia
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Hypermobility
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Osteoporosis
- ☐ Peripheral Artery Disease
- ☐ Peripheral Neuropathy
- ☐ Polio
- ☐ Rheumatic Fever
- ☐ Rheumatoid Arthritis
- ☐ Stomach Ulcers
- ☐ Stroke/TIA
- ☐ Tuberculosis
- ☐ Other:

Do you exercise regularly? Yes ____ No ____ If yes, explain how much, how often. Please describe frequency, duration, intensity and activity. _____

_____

I certify that I have answered the above questions truthfully and correctly, to the best of my knowledge. I will notify you of any changes in my health status or the above information.

A copy of this document may be utilized the same as the original.

_____ Date: _____

Patient/Parent/Guardian/Authorized Representative

If not signed by the patient, please indicate relationship to the patient on the line below:

_____