Rose Bowl Aquatics Center

Therapy Programs Intake Packet

PATIENT INFORMATION:

Last Name: _____ First Name: _____

Address: _____ City, State, Zip: _____

Date of Birth: _____ Gender: ____ Male ____Female

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email: _____

Occupation: _____

EMERGENCY CONTACT:

Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

HOW DID YOU FIND OUT ABOUT US?

____Friends or Family member ____ RBAC Member ____Former Patient

____ Website ____ Phone Book/ Yellow Pages ____Physician

____ Advertisement ____ Other _____

Why are you here today?

_____

_____

REFERRING PHYSICIAN:

Name: _____ Phone: _____

ALL OTHER PHYSICIANS:

Name: _____ Specialty: _____ Phone: _____

Name: _____ Specialty: _____ Phone: _____

Name: _____ Specialty: _____ Phone: _____

Name: _____ Specialty: _____ Phone: _____

Have you had Physical, Occupational, Speech, or Chiropractic Therapy in the past year? ____Yes ____No

Where? _____ How many visits? _____

Please check any of the following whose care you are under:

____Medical Doctor ____ Psychiatrist/Psychologist ____Osteopath

____Physical Therapist ____Dentist ____Chiropractor

____ Other _____

If you have seen any of the above in the past three months, please describe for what reason (illness, medical condition, physical, etc.):_____

_____

_____

Have you ever been diagnosed as having any of the following conditions? (Please circle)

Y N Do you wear external protection garments for bladder leakage or incontinence? ___Day ___Night
Y N Do you have stress or urgent incontinence?
Y N Cancer. If yes, describe what kind and date of diagnosis: _____
Y N Heart Attack
Y N Heart Arrhythmia
Y N Heart Valve Problems
Y N Do you have a pacemaker
Y N Deep Venous Thrombosis (Blood Clots)
Y N High Blood Pressure
Y N Circulation Problems
Y N Asthma
Y N Emphysema/Bronchitis
Y N Chemical Dependency (i.e. alcoholism)
Y N Thyroid Problems
Y N Diabetes
Y N Multiple Sclerosis
Y N Rheumatoid Arthritis
Y N Other Arthritic Conditions
Y N Fibromyalgia/ Chronic Fatigue
Y N Depression
Y N Hepatitis
Y N Stroke
Y N Kidney Disease
Y N Anemia
Y N Epilepsy/Seizures
Y N Osteoporosis/ Osteopenia
Y N Dementia
Y N Other _____

Please list any surgeries or other conditions for which you have been hospitalized, including the approximate date and reason for surgery or hospitalization:

	Date	Reason For Hospitalization/Surgery
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____

Please describe any significant injuries for which you have been treated (fractures, dislocations, sprains, etc.) and the approximate date of injury:

	Date	Injury
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____

Please list any PERSCRIPTION medications you are currently taking (pills, injections, skin patches, etc.)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Please list any OVER-THE-COUNTER medications you have taken during the past week:

Y N Aspirin
Y N Tylenol
Y N Advil/Motrin/Ibuprofen
Y N Laxatives
Y N Decongestants
Y N Antihistamines
Y N Antacid
Y N Vitamin/Mineral/ Herbal Supplements
Y N Other _____

General Health Questions:

Y N During the past month have you been feeling down, depressed, or hopeless?
Y N Do you ever feel unsafe at home or has anyone hit or tried to injure you in any way?
Y N Do you smoke cigarettes? How many cigarettes do you smoke per day? _____
Y N Do you chew tobacco?
Y N WOMEN: Are you currently pregnant or think that you might be pregnant?

How many caffeinated coffee or caffeine containing beverages do you drink per day? _____
How many days per week do you drink alcohol? _____ Average # of drinks per sitting? _____

Have you recently noted any of the following?

Y N Weight Loss/ Gain
Y N Nausea/Vomiting
Y N Fatigue
Y N Weakness
Y N Fever/Chills/Sweats
Y N Numbness/Tingling

Goals: Why are you coming here? What activities do you want to get back to?

_____

_____

_____

_____ _____
Patients Signature Date

_____ _____
Reviewed By - Physical Therapist Signature Date