Wellness and Prevention Intake Form

Name: _____ Male ☐ Female ☐ Height: _____ Weight: _____

Occupation: _____ General Health: Excellent ☐ Good ☐ Fair ☐ Poor ☐

Diet: _____

Exercise: _____

Smoking: Yes / No Alcohol: Yes / No If yes, how many drinks per day ☐ per week ☐ Occasional

Medical conditions: _____

Medications: _____

Assistive Devices: None ☐ Cane ☐ Walker ☐ Hearing aids ☐ Glasses ☐

Other: _____

Past Injuries/ Surgeries with dates: _____

_____

What are your goals/expectations for physical therapy? _____

_____