WINGARD
Wellness & Therapy Services

PATIENT INTAKE/HISTORY

Date of Onset or Surgery:_____ Current Pain Level (0-10):_____

Primary Complaint &/or Reason for Treatment:

_____

_____

Relevant Medical Conditions & History

[ ] Arthritis/Joint Problems
[ ] Asthma/Respiratory Problems
[ ] Anxiety/Panic Attacks
[ ] Cancer
[ ] Depressed of Withdrawn
[ ] Diabetes
[ ] Dizziness/History of Falling/Balance Issues
[ ] Heart Condition/Pacemaker/Defibrillator
[ ] High Blood Pressure
[ ] Low Blood Pressure
[ ] _____

[ ] Migraine Headaches
[ ] Night Sweats
[ ] Osteoporosis/Fractures
[ ] Pregnant (Currently)
[ ] Recent Fatigue/Weakness
[ ] Recent Illness (Cold/Flu)
[ ] Seizure/Epilepsy
[ ] Stroke
[ ] Unexplained Weight Loss/Gain
[ ] Smoking
[ ] _____

Allergies: [ ] No [ ] Yes _____

Prior Surgeries: [ ] No [ ] Yes _____

Are there religious or cultural beliefs/practices we need to consider in your care? [ ] Yes [ ] No

_____

Is there anything that would limit your ability to learn? [ ] No [ ] Yes _____

Preferred Learning Style: [ ] Written [ ] Verbal [ ] Demonstration

Have you had any therapy services in the last 60 days? [ ] No [ ] Yes

_____ _____

Patient/Parent/Legal Guardian's Signature Date

_____ _____

Clinician Signature Date