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 (insurance purposes) _____ Date_____
What do you want to be called? _____Pronouns_____
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? _____

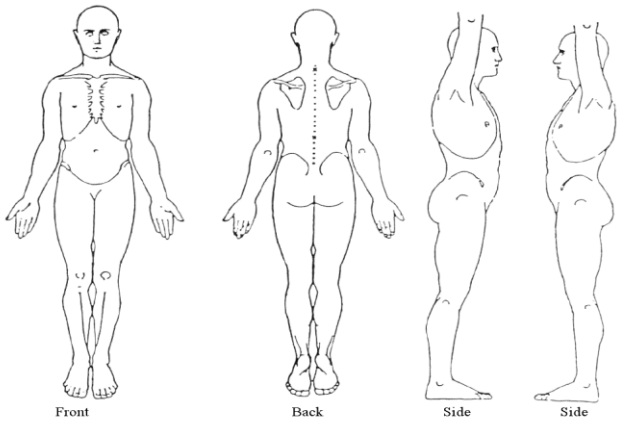
Current Complaint(s)

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? _____
_____
List your **primary** complaints (what we should focus on first): _____
_____
List your any other specific issues: _____

Rate your symptoms on the chart using a 0-10 scale (0 = no symptoms / best possible; 10 = absolute worst possible).

Rating out 10	Pain	Fatigue	Perceived Wellness
On average / most of the time:			
At it's worst:			
At it's best:			
Goal range:			

On the body diagram, please mark areas of your symptoms as they are at the time of your visit with a number from the 0-10 scale above.
CIRCLE YOUR PRIMARY COMPLAINTS.



What makes your symptoms worse?
_____
What makes your symptoms better? _____

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Are you pregnant? Yes ____ No ____

List any doctors you have seen for this condition and their specialty: _____

_____

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 medications & supplements & the condition for which you are taking them. (Attach separate page if needed).

Medication: _____ Condition: _____

Medication: _____ Condition: _____

Medication: _____ Condition: _____

Medication: _____ Condition: _____

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

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

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.

_____

Patient/Parent/Guardian/Authorized Representative Date

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

_____