**Glover Physical Therapy and Pain Rehabilitation**

**3620 Harlem Road, Suite 2 \* Cheektowaga, NY 14215 \* Phone (716) 446-9500 \* Fax (716) 446-9501**

## MEDICAL INTAKE FORM

### Patient SS#:

Date of Birth:

Emergency Contact:

Relationship: Telephone #:

Referring Physician:­­­­­­­­­­­­­­­­­­­­­­­­­­­­ Telephone #:

Family Physician / Internist: Telephone #:

#### MEDICAL INFORMATION: TO THE BEST OF YOUR KNOWLEDGE, DO YOU HAVE / HAVE HAD :

1. High Blood Pressure yes no 28. Blood in Stool / Ulcers yes no
2. Heart Disease Heart Attack yes no 29. Abdominal Pain yes no
3. Chest Pains / Angina yes no 30. Thyroid Problems yes no
4. High Cholesterol yes no 31. Polio / Muscle Disease yes no
5. Pacemaker yes no 32. Seizures yes no
6. Shortness of Breath yes no 33. Migraine/Cluster Headaches yes no
7. Asthma yes no 34. TMJ Disorders yes no
8. Allergies yes no 35. Chills/Fever/Sweats yes no
9. Chronic Bronchitis yes no 36. Chronic Headaches yes no
10. Blood Disorders yes no 37. Swelling of Extremities yes no
11. Emphysema yes no 38. Sleep Disorders yes no
12. Bleeding/Bruising yes no 39. Depression yes no
13. Anemia yes no 40. Fibromyalgia yes no
14. Diabetes yes no 41. Chronic Fatigue Syndrome yes no
15. Hypoglycemia yes no 42. Lyme’s Disease yes no
16. Lightheadedness yes no 43. Chronic Pain yes no
17. Dizziness yes no 44. Night Pain yes no
18. Concussion yes no 45. Unexplained Pain yes no
19. Fainting Disorders yes no 46. Unexplained Weight Loss yes no
20. Anxiety/Panic Attacks yes no 47. Cancer/Tumors/Growths yes no
21. Arthritis/Joint Pain yes no 48. History of Smoking yes no
22. Artificial Joints yes no 49. Are you pregnant? yes no
23. Kidney Disease/Stones yes no 50. Gynecological Disorders yes no
24. Hepatitis yes no 51. Bladder Incontinence yes no
25. Spinal Cord Injury yes no 52. Bowel Incontinence yes no
26. Traumatic Brain Injury yes no 53. Fractures yes no
27. Ulcers yes no Date:\_\_\_\_\_\_\_\_\_\_Area:\_\_\_\_\_\_\_\_\_\_\_\_

Date:\_\_\_\_\_\_\_\_\_\_Area:\_\_\_\_\_\_\_\_\_\_\_\_

CURRENT MEDICATIONS:

ALLERGIES:

1. To Medications:
2. To Other Substances:

SURGERY (S) Include Dates:

X-RAYS, MRI, CAT SCANS (Include Area & Dates):

SIGNATURE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: