Client Name: Today's Date:___________

WP INTAKE

DEMOGRAPHICS

Name: ______________________ Date of Birth: ______________

Address: Street ______________________ SSN: ______________

City State Zip ______________________ Work No: ______________

Email: ______________________ Cell:

__Male __ Female Age: _______

Marital Status				
__Married	__Divor	__Single	__Widowed	__Separated

Primary Care Physician ______________________ Tel: ______________

Current Health Condition

Chief complaint:

Tell me when and how it started:

Body area involved:

__Hip L / R	__Cervical (neck)	__Arms	L / R	Condition:	__New	__Recurring	__Chronic	__Exacerbation
__ Leg L / R	__Mid-back	__Wrists	L / R	Condition:	__New	__Recurring	__Chronic	__Exacerbation
__Knee L / R	__Pelvis	__Hands	L / R	Condition:	__New	__Recurring	__Chronic	__Exacerbation
__Ankle L / R	__Ribs	__Shoulder	L / R	Condition:	__New	__Recurring	__Chronic	__Exacerbation

Adult Illness

__Alzheimers	__Cystic Kidney Diease	__History of any of these symptoms	__Plurisy
__Anemia	__Depression	__HIV	__Pneumonia
__Arthritis	__Diabetes (insulin)	__Hypertension	__Psychiatric problems
__Asthma	__Diabetes (non-insulin)	__Influenza Pneumonia	__scoliosis
__Cancer	__Ear Infections	__Liver disease	__seizure disorder
__Chicken Pox	__Emphysema	__Lung Disease	__Shingles
__Chron's/Colitis	__eye problems	__Lupus Erythema (discoid)	__STD's (unspecified)
__CRPS	__Fibromyalgia	__Lupus Erythema (systemic)	__Sucide Attempt(s)
__CVA (stroke)	__Heart Disease	__Multiple Sclerosis	__Thyroid Problems
	__Hepatitis	__Parkinson's Disease	__Vertigo

__ I Deny having any adult illnesses

Client Name: Today's Date:___________

Childhood Illness

__ADD__Allergies __Bed Wetting __Ear Infection __HIV __Seizure Disorder
__Hayfever __Cerebral Palsy __Fetal Drug Exposure __Measels __Sickle cell anemia
__Asthma __Chicken Pox __Food Allergies __Mumps __spina Bifida
__Atopic Dermatitis __Depression __Headaches __Rash __Other (describe)___________________
__Eczema __Diabetes __Hepatitis __Scoliosis __I deny any childhood illness(es) __________

What Causes the activation of your chief complaint:

__Slip and Fall __Auto __Work __Fall __Lifting __Over Exertion __Repetitive Motion __Slept Wrong

__Other (explain): ____

Symptoms: __Pain __Stiffness __Numbness __Weakness

Location: __Left __Right __Bilateral

Quality: __Burning __Diffuse __Dull/Aching __Localized __Sharp __Shooting __Stabbing __Throbbing __Tingling

__Tightness __Radiating __Other (Explain):____

Scale of 1-10 rate your symptoms (10 being worst): At Rest:_____________ Date of event Duration: _________________

With Activity: ______ Duration: _________________

Timing worse in: ___Morning __Afternoon __Night __w/Activity __Constant __Intermittent

Associated signs & Symptoms: __Blurred __Vision __Depression __Dizziness __Headaches __Irritability
__Mood Swing __Localized Tingling __Nausea __Radiating __Ringing in Ears __Sleep __Disturbance __Stiffness.
__Aches __Cold Limb __Dizziness __Fatigue __Fever __Heartburn __Muscle Spasm __Nausea __Numbness
__Pale Bluish Skin __Panic __Pins & Needles __Runny Nose __Stiffness __Sweating __Swelling __Tingling
__Vomiting __Weakness

Headache:

__Dull __Throbs __Aura | __Radiates: __Left Side __Right Side __Bilateral
__Sharp __Stabs __No Aura | __Weakness: __Left Side __Right Side __Bilateral

Feels better with: __Cold __Heat __Activity __Bending __Massage __Movement __OTC meds __Rx Meds
__Rest __Stretching __Sitting __Standing __Twisting __Walking __Nothing Helps

Has any thing permanetly helped you with this condition? If yes what, __No __Yes :________________________________

Have you done anything that previously fixed the problem? If yes what, __No __yes: _________________________________

Client Name:

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Daily Activities: On a scale of 0-10 (10 =unable to do), what level are you experiencing symptoms while performing these activities

Bending	______	Family Care	______	Pet Care	______	Static Standing	______
Driving	______	Carrying Groceries	______	Reading	______	Static Sitting	______
Feeding	______	Computer Use	______	Sleep	______	Sexual Activities	______
Kneeling	______	Change pos. sit-stand:	______	Walking	______	Self care shaving	______
Lifting	______	Climb stairs	______	Yard work	______	self care bathing	______
		Household Chores	______	Other:	____________		

Below is a list of diseases that may seem unrelated to the purpose of your appointment. Owever, these questions must be answered carefully as the probems can affect your overal course of care. Review symptoms. Fill out all the sections, select "Deny" if you symptoms in the category is not applicable to you.

Constitutional:	Respiration:	Cardiovascular:	
__Chills	__Asthma	__Angina	__Swelling of Legs
__Night Sweats	__Coughing Blood	__Chest pain/discomfort	__Ulcers
__Weight Gain	__Sputum	__Leg Pain/Achiness	__Vericose veins
__Weight Loss	__Cough	__Heart murmur	__Palpitations
__Fatigue	__Shortness of Breath	__Difficulty breathing in lying down (Orthopnea)	__Heart Problems
__Fatigue	__Wheezing	__Walking at Night with Shortness of breath(paroxysmal)	__I Deny cardio-vascular Issues
__Fever	__Pain with breathing		
__I Deny Cons-titutional Issues	__I Deny respiratory Issues		

Gastrointestinal	Endocrine	Skin	Nervous
__Nausea	__Hot	__varicosities	__unsteady of gait
__Abdominal pain	__Cold	__Changes in nail texture	__Dizziness
__Belching	__Diabetes	__Changes in skin color	__ Facial weakness
__Constipation	__Excessive Appetite	__Hair growth	__Headaches
__Diarrhea	__Excessive Hunger	__Hair loss	__Limb Weakness
__Heartburn	__Excessive Thirst	__Hives	__Loss of consciousness
__Hemorrhoids	__Frequent urination	__Itching	__Loss of memory
__Indigestion	__Goiter	__Paresthesia	__Numbness
__Jaundice	__Hair Loss	__Rash	__Seizures
__Abnormal Stool color		__History of skin disorders	__Sleep disturbance
__Abnormal Stool consisten	__I Deny any Endocrine Issues	__Skin Lesions/ulcers	__Stress
__Vomiting			__Strokes
__I Deny Gastro-intestinal Issues		__I Deny any skin issues	__Tremors
			__I deny any issues with Nerveous system

Allergy				
__Anaphylaxis	**__Food coloring**	**__Eggs**	**__Pollen**	**__I Deny any allergy issues**
__Itching	__Food Intolerance	__Essential Oils	__Animals	
__Sneezing	__Naisal Congestion	__Dairy	__Mold	

Client Name: Today's Date:___________

Surgeries

__Angioplasty __Coronary Artery Bypass __Hemorrhoidectomy __Laminectomy
__Appendectomy __Cosmetic __Hernia Repair __Mastectomy
__Cesarean Section __D & C __Hysterectomy __Pacemaker Insertion
__Cardiac Catheterization __Dental Surgery __Joint reconstruction __Rotator Cuff
__Carpal Tunnel __Gall Bladder __Joint Replacement __Spinal Fusion
Other (explain)___________________________________ __I Deny any surgery(ies)

Injuries

__Back Injury __ Industrial Accident __Mild/moderate soft tissue injury __Head Injury
__Fracture __Joint Injury __Broken Bones __Severe Laceration
__Disability __Motor vehicle accident __Severe Fall __Severe soft tissue injury

__I deny any injuries

Are you up todate on your immunizations? Which ones

__ DTAP (Diptheria, Tetanus & Pertussis) __Flu __Hepatitis A __Hepatitis B __Hepatitis C __Influenza __Polio

__Mumps, Measles & Rubella __Pneumococcal __PPD TB Test __Small Pox __TB __Chicken Pox __Whopping Cough

Social History	Amount	Daily	Weekly	Month	Social	Never
__Alcohol	_______	_______	_______	_______	_______	_______
__Tobacco	_______	_______	_______	_______	_______	_______
__Drugs	_______	_______	_______	_______	_______	_______
__Special Diet (describe)						

Employment/Occupation

Job Title/Occupation ______________________________ Type of work:

Company: ______________________________________ Tel: _________________________

Work Activity Posture:	Lifting Frequency:	Repetitive Activities
__Sitting __Standing __ Walking __Climbing	__Constant (66-100%/day)	__Computer __Hand Tools
__Pushing __Pulling __Kneel __Reach	__Frequent (33-35%/day)	__Phone __Assembly
__Twisting __Bending __Other:	__Occasional (0-32%/day)	__Machinery __Grasping

How does this condition effect job performance:

__Mild Pain (can do job) __ Severe (unable to perform) __Moderate Pain (limited)
__Other (explain):

Client Name: Today's Date:___________

History of Falls/Loss of Balance

No. of Falls this year: _______ __Occasionally __Frequently __Constantly __I deny experiencing falls

Do you use or require use of any assistive equipment at home? __ Yes __No

Prior to your current problem did you walk using a device? __ Yes __No

Please select device used now or prior to current problem: __Cane __Crutches __Standard Walker __Rolling Walker
___ Other (please list):

Please write a statement regarding any medical conditions or physical health concerns not mentioned above that we should know in order to provide you with the best care today and in the future:

Please List all current medications and Supplements you are currently taking:

Name of Medicine	Dose	Effective	Not Effective	Daily Supplement	Effective	Not Effective
				Multi-vitamins		
				Calcium		
				Vitamin B		
				Vitamin D		
				Antioxidant		
				Magnesium		
				Omega 3		
				Probiotics		
				Iron		

I understand I must read WP policies on financial responsbility, privacy and practice obligations. i agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Although WholePerson Therapeutics (WPT) accept insurance for services that are medically necessary, the services I receive from WPT is functionally necessary and not be covered by my insurance. I understand that payment for all services received is due and payable at my session. I have been provided access to WPT policies and its location on both the website: www.WP-Therapeutics.com and the client portal at SimplPractice.com. I have been provided contact information for WPT office should I have any additional questions. I hereby authorize WPT to proceed with treatment applicable to my condition, as the therapist deem appropriate, through use of occupational therapy, other professional training and principles. I further authoritize WPT to securely store and charge my credit/debit card information for payment of services rendered.

Signature indicates I understand the above policy, consent to treat and charge my credit card for services rendered.

SIGN: ______________________________ **DATE:** ____________

PRINT: ______________________________