RUNSEATTLEPT

Questions about how to complete this form?
Call 206-465-5650

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www.runseattlept.com

Return completed form to:
106 Lakeside Ave,
Seattle, WA 98122

Medical History / Health Intake

NAME | BIRTH DATE

WHAT PROBLEM(S) ARE YOU SEEKING TREATMENT FOR?

WHEN DID SYMPTOMS START?

WHAT MAKES SYMPTOMS WORSE? | WHAT MAKES SYMPTOMS BETTER?

SYMPTOMS ARE CURRENTLY ☐ Constant ☐ Intermittent ☐ Constant (but change with activity)

SYMPTOMS ARE CURRENTLY ☐ Getting Better ☐ Getting Worse ☐ Staying the Same

IN THE PAST 24 HOURS (0 NO PAIN, 10 EXTREME PAIN) Pain at worst _____ Pain at best _____

HAVE YOU RECEIVED PRIOR TREATMENT FOR THIS CONDITION? IF SO, WHEN, WHERE, AND HOW MUCH?

HAVE YOU RECEIVED IMAGING FOR THIS CONDITION? (X-RAY, MRI, ULTRASOUND, CT, ETC.) IF SO, WHEN?

Medical History

HAVE YOU RECENTLY NOTED ANY OF THE FOLLOWING (CHECK ALL THAT APPLY)

- ☐ Change in bowel or bladder function
- ☐ Nausea / vomiting
- ☐ Headaches
- ☐ Balance problems or falls
- ☐ Weight loss / gain
- ☐ Fever / chills / sweats
- ☐ Changes in appetite
- ☐ Shortness of breath
- ☐ Weakness / fatigue
- ☐ Dizziness / lightheadedness
- ☐ Difficulty swallowing
- ☐ Numbness / tingling
- ☐ Pain at night
- ☐ Vision changes

PLEASE LIST ALL MEDICAL HISTORY (DIAGNOSIS, SURGERIES, FALLS, ETC.) INCLUDING DATES

PLEASE LIST ANY ALLERGIES (LATEX, FOOD, MEDICATION, ETC.)

ARE YOU PREGNANT? ☐ Yes ☐ No | IF SO, HOW MANY WEEKS? Weeks _____

Medications

PLEASE LIST ANY MEDICATIONS, VITAMINS, SUPPLEMENTS, OR OVER THE COUNTER DRUGS YOU ARE CURRENTLY TAKING. A COPY CAN BE MADE OF A DETAILED LIST IF YOU HAVE ONE.

Medication _____ Dose _____ Frequency _____

Medication _____ Dose _____ Frequency _____

Medication _____ Dose _____ Frequency _____

Medication _____ Dose _____ Frequency _____

DO YOU CONSUME MORE THAN 7 ALCOHOLIC BEVERAGES IN A WEEK? ☐ Yes ☐ No

DO YOU USE TOBACCO? ☐ Yes ☐ No | IF YES, WHAT KIND AND HOW OFTEN?

DURING THE PAST MONTH, HAVE YOU BEEN FEELING DOWN, DEPRESSED, OR HOPELESS? ☐ Yes ☐ No

DURING THE PAST MONTH, HAVE YOU HAD LITTLE INTEREST OR PLEASURE IN DOING THINGS? ☐ Yes ☐ No

IS THERE ANYTHING ELSE WE SHOULD KNOW PERTINENT TO YOUR TREATMENT?

WHAT IS YOUR GOAL FOR THERAPY?

PATIENT NAME | DATE