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:
A. To Medications:____
B. To Other Substances:____
SURGERY (S) Include Dates:____
X-RAYS, MRI, CAT SCANS (Include Area & Dates): ____
____

SIGNATURE:____Date:______________________________