Hillcrest
PHYSICAL THERAPY & WELLNESS
Optimum Results, Healthy Living

PATIENT INFORMATION

First Name _____ MI ____ Last_____ Preferred Name _____

Mailing Address _____ City _____ State _____ Zip_____

Primary Phone _____ Cell Phone _____ Email _____

Date of Birth ___/___/___ Marital Status _____ Social Security Number _____

Emergency Contact _____ Phone _____ Relationship _____

How did you hear about us? _____

Would you like to receive appointment reminders? □ E-mail □ Text Message □ Decline Reminders

Primary Care Provider _____

Referring Provider (if different) _____

Next Appointment with Primary Care or Referring Provider _____

Medical Diagnosis or Primary Concern _____

Approximate Date of Onset _____

Have you received Home Health Services this year? □ YES □ NO

INSURANCE INFORMATION

Please bring **all** of your current insurance cards and your ID to your appointment.

Primary Insurance _____ Member ID # _____ Group #_____

Responsible Party Name _____ Date of Birth _____ SS# _____

Secondary Insurance _____ Member ID # _____ Group #_____

4215 University Drive, Suite B2
Durham, NC 27707

Phone 919-627-6700
Fax 919-627-6627

ALLERGIES & CURRENT MEDICATIONS

ALLERGIES

□ No known Allergies

□ Latex Allergy

□ Medication Allergies

_____

_____

MEDICATIONS

□ I am not currently taking any prescription medications, supplements, or over-the-counter medications

1. Medication _____
   Frequency _____ Dosage _____

2. Medication _____
   Frequency _____ Dosage _____

3. Medication _____
   Frequency _____ Dosage _____

4. Medication _____
   Frequency _____ Dosage _____

5. Medication _____
   Frequency _____ Dosage _____

6. Medication _____
   Frequency _____ Dosage _____

7. Medication _____
   Frequency _____ Dosage _____

8. Medication _____
   Frequency _____ Dosage _____

9. Medication _____
   Frequency _____ Dosage _____

10. Medication _____
    Frequency _____ Dosage _____

□ Patient brought medication list. Scanned into file.

□Medication list received from referring provider. Scanned into file.

MEDICAL HISTORY INTAKE FORM

Do you now or have you ever had any of the following? (Please check all that apply)

_____ Alzheimer's disease/Dementia
_____ Anemia
_____ Arthritis
_____ Asthma, Bronchitis, or Emphysema
_____ Blood Clot/Emboli
_____ Bowel or Bladder Problems
_____ Brain Injury
_____ Cancer
_____ Cellulitis
_____ Chemotherapy/Radiation
_____ Congestive Heart Failure
_____ COPD
_____ COVID-19
_____ Coronary Heart Disease or Angina
_____ Defibrillator
_____ Diabetes
_____ Drug/Alcohol Dependency
_____ Emotional/Psychological Problems
_____ Epilepsy/Seizures
_____ Fibromyalgia
_____ Gastric Reflux
_____ Gout
_____ Heart Attack or Surgery
_____ Hepatitis
_____ Hernia
_____ High Blood Pressure
_____ Joint Replacement
_____ Kidney Disease
_____ Lupus
_____ Lymphedema/Lipedema
_____ Multiple Sclerosis (MS)
_____ Currently Pregnant/Breastfeeding
_____ Osteoporosis
_____ Pacemaker
_____ Parkinson's Disease
_____ Psoriasis
_____ Severe or Frequent Headaches
_____ Shortness of Breath/Chest Pain
_____ Sleeping Problems/Difficulties
_____ Spinal Cord Injury
_____ Stroke/TIA
_____ Thyroid Trouble/Goiter
_____ Venous Insufficiency
_____ Currently receiving Wound Care

GENERAL HEALTH

1. I would rate my health as: □ **Excellent** □ **Good** □ **Fair** □ **Poor**
2. Have you notice any lumps or thick skin/muscle anywhere on your body? □ **Yes** □ **No**
3. Do you have any sores that have not healed or any changes in size, shape, or color of a wart or a mole? □ **Yes** □ **No**
4. How many alcoholic drinks do you consume each week? _____
5. How much water do you consume daily? _____
6. Do you smoke or chew tobacco? □ **Yes** □ **No** □ **Quit**, if so when? _____
7. Are you on any special diet? □ **Yes** □ **No**
8. Do you currently exercise? □ **Yes** □ **No**
   How often? _____ Types of exercise _____
9. How many falls have you had in the past year? _____

10. Describe problems with your balance or fear of falling. _____

11. Have you been vaccinated for COVID-19? □ **Yes** □ **No**

12. Do you have, or have you recently had any of these problems?

_____ Blood in urine, stool, vomit. mucous	_____ Numbness or tingling
_____ Dizziness, fainting, or blackouts	_____ Swelling or lumps anywhere
_____ Fever, Chills, day or night sweats	_____ Problems seeing and/or hearing
_____ Changes in bowel/bladder functions	_____ Unusual fatigue or drowsiness
_____ Unexplained weight loss	_____ Difficulty swallowing or speaking
_____ Skin rash or changes	_____ Memory loss
_____ Cough	_____ Confusion
_____ Urinary issues/stress incontinence	_____ Sudden weakness
_____ Heart Palpitations	_____ Trouble sleeping
_____ Throbbing sensation in belly/elsewhere	_____ Jaw pain, noise, teeth grinding

13. Over the last 2 weeks, have you had little interest or pleasure in doing things? □ **Yes** □ **No**

14. Over the last 2 weeks, have you been feeling down, depressed, or hopeless? □ **Yes** □ **No**

15. Do you have any braces, ankle foot orthoses (AFOs), orthotics, or prosthetic devices? □ **Yes** □ **No**
    If yes, how often do you wear these devices?_____

MEDICAL AND SURGICAL HISTORY

1. Have you ever undergone chemotherapy or radiation therapy? □ **Yes** □ **No**
2. Have you had any X-rays, CT scans, MRIs, bone scans, or other images recently? □ **Yes** □ **No**
   What? _____ When? _____ Results? _____
3. Have you had any lab work recently? □ **Yes** □ **No**
   Results _____
4. Have you undergone any other treatment for the condition you are being seen for today? □ **Yes** □ **No**
5. Please list any significant surgeries.

   _____

   _____

   _____

   _____

6. Do you have a pacemaker, breast implants, or any other implants? □ **Yes** □ **No**

SOCIAL HISTORY

Occupation or Primary Job Demands (for example, prolonged sitting/standing, computer work, lifting, pulling, etc.)_____

_____

_____

Job Status

□ Working full time, regular duty

□ Working restricted hours, regular duty

□ Out of work secondary to injury

□Working full time, light duty

□ Working restricted hours, light duty

□ Unemployed

□ Retired

Please describe your living situation? Who do you live with?

_____

_____

_____

My personal goal(s) from physical therapy treatment are:_____

_____

_____

PAIN ASSESSMENT

Regarding the injury for which you are seeing us today, please rate your pain level:

Pain at **LOWEST**: Rate your **lowest** pain **IN THE PAST 3 DAYS.**

0 1 2 3 4 5 6 7 8 9 10
no pain worst pain

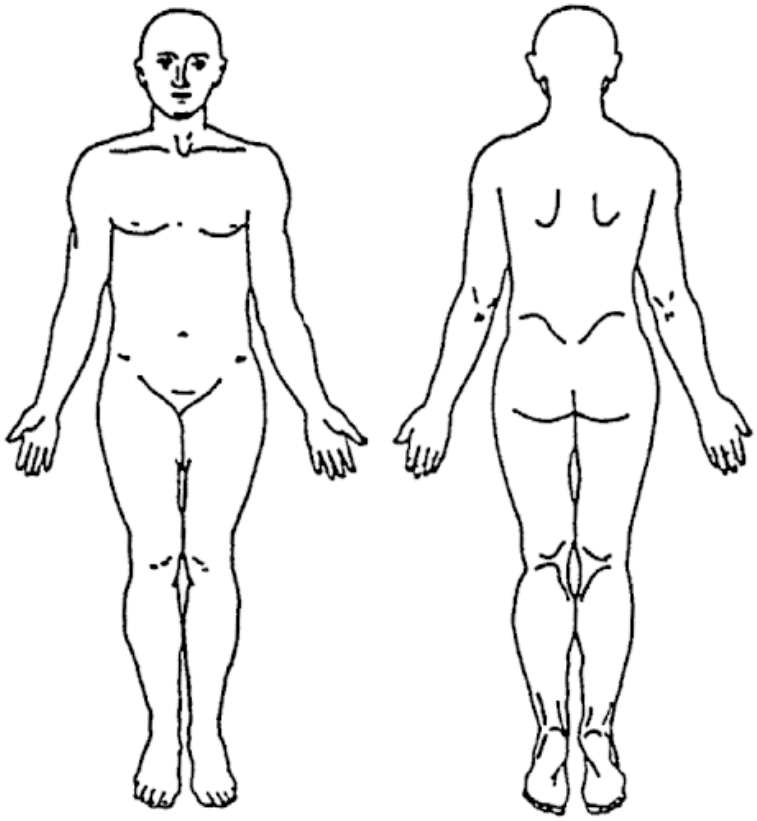
Pain **CURRENTLY**: Rate your level of pain **NOW.**

0 1 2 3 4 5 6 7 8 9 10
no pain worst pain

Pain at **WORST**: Rate your **highest** pain level **IN THE PAST 3 DAYS.**

0 1 2 3 4 5 6 7 8 9 10
no pain worst pain

Please mark where you are having your pain using the following: Pain xxx Numbness ooo Tingling zzz



What makes your pain better? _____

What makes your pain worse? _____