Thank you for choosing Key Therapeutics, LLC

Client Health Profile

Date: ___________________________

Name: ___________________________________Date of Birth: _______________________Gender: _____________

Home Phone: ________________________Cell Phone: ________________________Marital Status: _________

Address: ____

City/State/ Zip Code: ____

Email : __________________________Primary Care Provider/ Phone : ___________________________________

Emergency Contact: _________________________Emergency Phone # __________________________________

Because your symptoms can be produced by a combination of many interrelated factors, it is important that you disclose *if you have ever* suffered from the following conditions:

Please check all that apply, and indicate when first discovered/diagnosed:

___ Allergies/ Asthma
___ Anemia
___ Arthritis _______________
____Arrythmia
___ Anxiety
___ Autoimmune Disease
___ Balance Issues
___ Blood Disorder/ Clots
___ Cancer ________________
___ Chest Pain
___ COVID _________________
___ Concussion ____________
___ Diabetes
___ Depression

___ Digestive Disorder/ IBS
___Epilepsy/ Seizure Disorder
___ Fainting Spells
___ Fibromyalgia
___ Growth / Tumors
___ Heart Disease
___ HIV
___ Hives/ Skin Rashes
___High or Low Blood Pressure
___ Hepatitis/ Jaundice
___ Headaches
___ High Cholesterol
___ Inflammation
___ Kidney Disease

___ Liver Disease
___ Lyme Disease
___ Migraines
___ Pacemaker
___ Pelvic Floor Pain
___ PTSD
___ Sexual Disfunction
___ Sinus Pain/Infection
___ Scoliosis/ Kyphosis
___ Spinal/ Brain Injury
___ Stroke/ TIA
___ Surgically Implanted Device
___ Stents
___ Vertigo

Other: ____

Please detail all surgeries, medical procedures or serious medical conditions as noted above:
____
____

Key Therapeutics, LLC

Please list any medications you have taken in the past 12 months or that you are currently taking including dosage:

____

Please rate your chief complaint in order of severity:

___ Pain

___ Swelling/Edema

___ Decreased Range of Motion

___ Stiffness

___ Loss of Function

___ Numbness/Tingling

___ Fatigue/Body Aches

___ Preventative

___ Other (please describe below)

Please circle Yes or No to the following questions:

Has there been any change in your general health in the past year?
No Yes: ____

Are you now under the care of a medical doctor?
No Yes: ____

Have you been hospitalized or been treated for a serious illness in the past five (5) years?
No Yes: ____

Does your current complaint interrupt your sleep or cause you to wake earlier than normal?
No Yes: ____

Do you experience intolerance to hot or cold or have issues with circulation?
No Yes: ____

Have you had a bone scan or been diagnosed with osteoporosis/osteopenia?
No Yes

Have you experienced dizziness, vertigo, nausea or vomiting?
No Yes: ____

Do you have a history of injury to any part of your body? If so, where and when?
No Yes:

____

Are you or could you be pregnant? No Yes (how far along) ____ Number of past pregnancies ______
Number of Live Births _________ Number of C-Sections _________Number of Vaginal Births ______

Have you had any recent changes in your weight or appetite?

No Yes: ____

Have you noticed any decrease in exercise tolerance or exercise induced shortness of breath?
No Yes: ____

Karen Andrews, P.T., MTC, CSC1
(P) (240) 405-4424
karen@keypt.us

Key Therapeutics, LLC

Do you use any type of orthotic or assistive device?
No Yes: ____

Have you experienced any other illness or injury that could impact your care?
No Yes: ____

If you answered yes to any of the above and would like to provide more details below:

____

____

Social and Occupational Profile

Are you presently employed? ________Yes _________No

Physical/Emotional demands of job: _______ High ________ Moderate ______ Minimal_________

Overall activity level: ________ Sedentary _________ Light ________ Moderate _________ Heavy

Sports/Exercise: ____________Type ____________ Frequency ___________ Duration

Use of Tobacco ___________ Alcohol _____________ Other _____________

Have you seen or consulted with any of the following: ________ M.D. ________ P.T.

________ Acupuncturist ________ Mental Health ________ Chiropractor

________ Massage Therapist ________ Personal Trainer ________ Rehab/Pilates

Have you undergone testing or diagnostic imaging for your condition (x-ray, MRI, dexa scan, etc.)

____

Please list 3 goals of your physical therapy and your desired timeframes:

1)____

2)____

3)____

Is there any additional information that you would like to provide that has not been addressed in this Client Health Profile?

____

____

How did you hear about us?

Karen Andrews, P.T., MTC, CSC1
(P) (240) 405-4424
karen@keypt.us