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	___ Digestive Disorder/ IBS	___ Liver Disease
___ Anemia	___Epilepsy/ Seizure Disorder	___ Lyme Disease
___ Arthritis _____	___ Fainting Spells	___ Migraines
____Arrythmia	___ Fibromyalgia	___ Pacemaker
___ Anxiety	___ Growth / Tumors	___ Pelvic Floor Pain
___ Autoimmune Disease	___ Heart Disease	___ PTSD
___ Balance Issues	___ HIV	___ Sexual Disfunction
___ Blood Disorder/ Clots	___ Hives/ Skin Rashes	___ Sinus Pain/Infection
___ Cancer _____	___High or Low Blood Pressure	___ Scoliosis/ Kyphosis
___ Chest Pain	___ Hepatitis/ Jaundice	___ Spinal/ Brain Injury
___ COVID _____	___ Headaches	___ Stroke/ TIA
___ Concussion _____	___ High Cholesterol	___ Surgically Implanted Device
___ Diabetes	___ Inflammation	___ Stents
___ Depression	___ Kidney Disease	___ Vertigo

Other: _____

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

_____

_____

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 : _____

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

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

____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?

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