Sierra Therapy Intake Form

SIERRA THERAPY

Demographics

Name:

Date form completed:

Address:

City: **State:** __ **Zip:**

Phone number:

Email address:

Date of birth: **Age:** years

Sex (assigned at birth)**:** ☐ Female ☐ Male

Gender identity:

☐ Female ☐ Transgender
☐ Male ☐ Trans-female
☐ Trans-male ☐ Other
☐ Nonbinary/gender-nonconforming
☐ Prefer not to say

Sexual orientation:

☐ Straight/heterosexual
☐ Gay or lesbian
☐ Bisexual
☐ Other
☐ Prefer not to say

Ethnicity/race:

☐ Hispanic, Latino, or Spanish
☐ Black or African American
☐ American Indian or Alaska Native
☐ Chinese, Filipino, Asian Indian, Vietnamese, Korean, Japanese, or other Asian
☐ White
☐ Native Hawaiian, Samoan, Chamorro, or other Pacific Islander
☐ Prefer to self-describe: Click here.
☐ Prefer not to say

Education Level (highest grade completed)**:**

☐ K-12
☐ Some college / technical school
☐ College graduate
☐ Graduate school / advanced degree

Occupation/employment status:

☐ Retired
☐ Full-time
☐ Part-time
☐ Unemployed

Enough food to eat: ☐ Yes ☐ No

Adequate housing: ☐ Yes ☐ No

Access to health care: ☐ Insured ☐ Underinsured ☐ Uninsured

Preferred/primary language:

Primary care health care provider:

Other relevant health care provider(s):

Are you currently seeing a physical therapist?

Have you seen a physical therapist in the last year?

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Emergency contact name: **Phone number:**

Patient and Client Health and Wellness Goals

Relevant Medical History		
Current Medications:		
Have you been advised by a medical provider not to exercise?	☐ Yes ☐ No	
Height: feet inches	**Weight:** lbs.	
Do you have any of the following medical conditions?		**Comments:**
High blood pressure (BP)/hypertension	☐ Yes ☐ No	What is your usual BP:
Heart attack	☐ Yes ☐ No	
Heart surgery, cardiac catheterization, or coronary angioplasty	☐ Yes ☐ No	
Pacemaker, implantable cardiac defibrillator, rhythm disturbance	☐ Yes ☐ No	
Heart valve disease	☐ Yes ☐ No	
Heart failure	☐ Yes ☐ No	
Heart transplant	☐ Yes ☐ No	
Congenital heart disease	☐ Yes ☐ No	
Blood disorders (anemia)	☐ Yes ☐ No	
Diabetes or high blood sugar	☐ Yes ☐ No	
Hypoglycemia or low blood sugar	☐ Yes ☐ No	
Kidney/urinary problems (urgency, leakage)	☐ Yes ☐ No	
Arthritis (osteoarthritis, rheumatoid arthritis)	☐ Yes ☐ No	
Osteoporosis or bone fractures	☐ Yes ☐ No	
Musculoskeletal problems	☐ Yes ☐ No	
Lung Problems (COPD, asthma, shortness of breath)	☐ Yes ☐ No	
Depression	☐ Yes ☐ No	

Neurologic diseases (Parkinson disease, multiple sclerosis, stroke)	☐ Yes ☐ No	
Head injury	☐ Yes ☐ No	
Seizures, epilepsy	☐ Yes ☐ No	
Cancer of any type	☐ Yes ☐ No	
Thyroid problems	☐ Yes ☐ No	
Stomach problems, ulcers	☐ Yes ☐ No	
Bowel problems (constipation, gas/stool leakage)	☐ Yes ☐ No	
Chronic pain	☐ Yes ☐ No	
Altered sensation in hands, legs, feet	☐ Yes ☐ No	
Wounds/ulcers/skin diseases	☐ Yes ☐ No	
Infectious disease (e.g., tuberculosis, hepatitis)	☐ Yes ☐ No	
Allergies (seasonal or other)	☐ Yes ☐ No	
Balance or coordination problems	☐ Yes ☐ No	
Difficulty swallowing	☐ Yes ☐ No	
Major surgery	☐ Yes ☐ No	
In the past year, have you experienced any of the following symptoms? If yes, please provide details.		**Comments:**
Chest discomfort with exertion	☐ Yes ☐ No	
Unexpected shortness of breath	☐ Yes ☐ No	
Dizziness, fainting, or blackouts	☐ Yes ☐ No	
Ankle swelling	☐ Yes ☐ No	
Unpleasant awareness of forceful, rapid, or irregular heart rate	☐ Yes ☐ No	
Burning or cramping sensations in lower legs when walking a short distance	☐ Yes ☐ No	

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Is there any other information about your health or medical history you want to share? ☐ Yes ☐ No

Current Health Habits

Exercise

Do you exercise regularly? ☐ Yes ☐ No

Describe your average weekly exercise regimen:

Click here to enter text.

On average, how many days a week do you perform moderate to vigorous intensity physical activity or exercise where your heart is beating faster and your breathing is harder than normal (such as a brisk walk)? **Days per week:**

On average, how many minutes do you engage in exercise at a moderate to vigorous level? **Minutes per day:**

How many minutes per day or hours per week do you spend sitting? **Minutes/day:**

Hours/week:

Do you participate in muscle-strengthening activities? ☐ Yes ☐ No

Do you perform balance-training activities? ☐ Yes ☐ No

Tobacco / nicotine use

Do you currently use any tobacco or nicotine products? ☐ Yes ☐ No
This includes cigarettes, cigars, chewing tobacco, vaping, etc.

If yes, what type of products do you use? How much do you use on a daily basis?

☐ Cigarettes: ☐ Cigar: ☐ Chew:

☐ Snuff: ☐ Vapor: ☐ Other:

If you use tobacco or nicotine products, are you interested in quitting? ☐ Yes ☐ No

Alcohol use

Do you drink alcohol? ☐ Yes ☐ No

If yes, # of drinks per day: Beer: Wine: Liquor:

Diet

How would you rate your diet? ☐ Good ☐ Fair ☐ Poor

How many servings of fruits and vegetables do you eat per day?

How many cups or ounces of water do you drink per day?

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Sleep	
Do you have difficulty falling asleep at night?	☐ Yes ☐ No
Do you wake up at night?	☐ Yes ☐ No
Do you snore or been told you snore?	☐ Yes ☐ No
On average, how many hours do you sleep per night?	Hours
Hearing	
Do you feel you have a hearing loss?	☐ Yes ☐ No
Functional activity review	
Can you walk four blocks (1/2 mile) at a brisk pace?	☐ Yes ☐ No
How far can you walk before you get fatigued?	
Can you climb one flight of stairs?	☐ Yes ☐ No
How many flights of stairs can you climb before you get fatigued?	Flights
Can you carry five pounds of groceries up one flight of stairs without fatigue?	☐ Yes ☐ No
Can you get on and off the floor by yourself?	☐ Yes ☐ No
Can you stand up from a chair without using your arms?	☐ Yes ☐ No
While standing, can you turn in a circle (360 degrees) to the right and/or left?	☐ Yes ☐ No
Can you pick up a penny off the floor?	☐ Yes ☐ No
Can you participate in strenuous sports, such as swimming, singles tennis, football, basketball, or skiing?	☐ Yes ☐ No
Do you have difficulty with any other daily activity like dressing, bathing, toileting, getting in or out of a car?	☐ Yes ☐ No
Falls history	
Have you fallen in the past year? If so, how many times?	☐ Yes ☐ No
Do you feel unsteady when standing or walking?	☐ Yes ☐ No
Do you worry about falling?	☐ Yes ☐ No

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