Blake & Associates, Inc.
Physical Therapy

5754 Bridgetown Road • Cincinnati, OH 45248
(513) 661-6555 • Fax (513) 661-6556 • www.blakeandassociatespt.com

Initial Medical Survey (IMS)

DATE _____ NAME _____

HEIGHT _____ WEIGHT _____ OCCUPATION _____

LEISURE ACTIVITIES_____

How many caffeinated beverages do you drink per day? _____ How many days per week do you drink alcohol? _____

How many packs of cigarettes do you smoke per day? _____

1) Please check any of the following whose care you're under:

_____ Medical Doctor (MD) _____ Psychiatrist/Psychologist _____ Podiatrist _____ Dentist

_____ Osteopath _____ Physical Therapist _____ Chiropractor _____ Other _____

If you have seen any of the above during the past 3 months, describe the reason: _____

_____

2) Please describe any significant injuries for which you have been treated including the approximate date of injury:

DATE	INJURY	DATE	INJURY
_____	_____	_____	_____
_____	_____	_____	_____

3) Please list any surgeries or conditions for which you have been hospitalized. Include an approximate date and reason for the surgery/hospitalization:

DATE	REASON	DATE	REASON
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

4) Have you EVER been diagnosed as having:

YES NO Covid19, if YES, list date(s) _____

YES NO Cancer, if YES, describe what kind _____

YES	NO	Heart Problems	YES	NO	High Blood Pressure	YES	NO	Circulation Problems
YES	NO	Asthma	YES	NO	Emphysema/Bronchitis	YES	NO	Chemical Dependency
YES	NO	Thyroid Problems	YES	NO	Diabetes Type I or II	YES	NO	Hepatitis
YES	NO	Osteoarthritis	YES	NO	Multiple Sclerosis	YES	NO	Depression
YES	NO	Rheumatoid Arthritis	YES	NO	Parkinson's	YES	NO	Stroke
YES	NO	Kidney Disease	YES	NO	Anemia	YES	NO	Fibromyalgia

Patient Name _____

5) Please list any prescription medications you are currently taking: **(INCLUDE DOSAGE)** _____

_____

_____

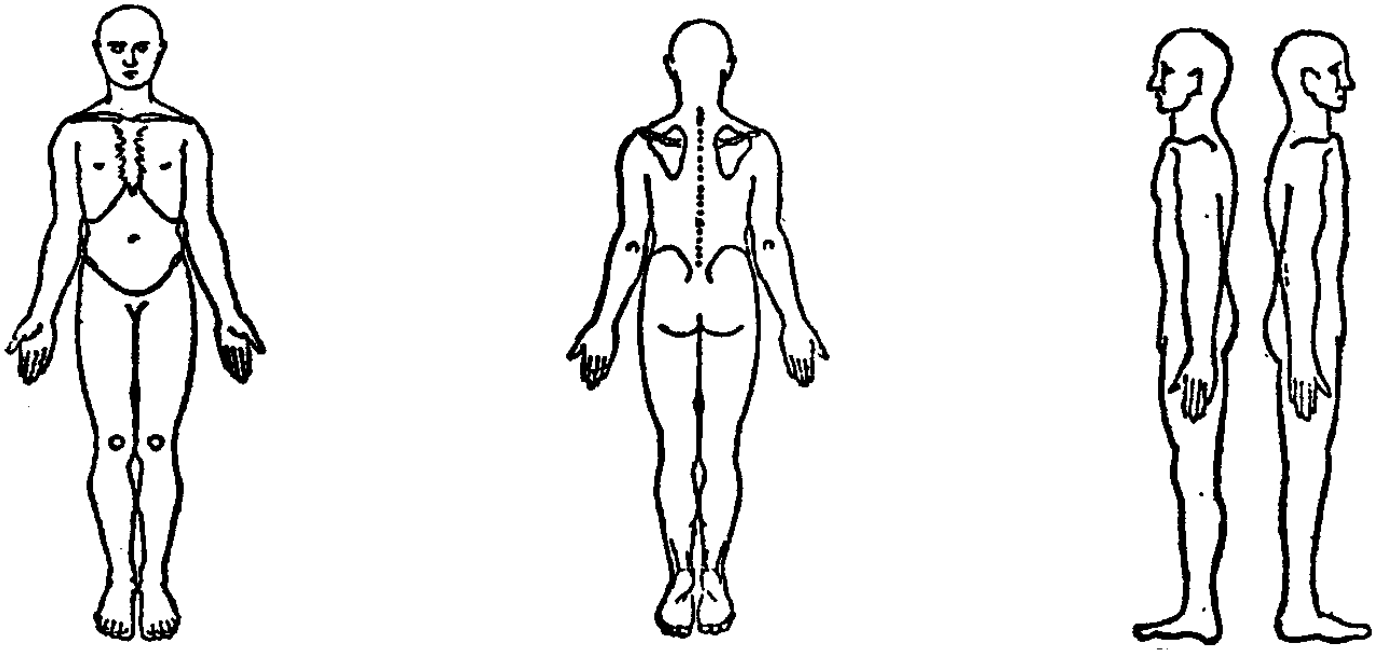
6) ALLERGIES: List all allergies, especially medications: _____

Are you latex sensitive? YES NO

7) Have you recently noted

YES	NO	Weight Loss/Gain	YES	NO	Nausea/Vomiting	YES	NO	Dizziness/Lightheadedness
YES	NO	Fatigue	YES	NO	Weakness	YES	NO	Fever/Chills/Sweats
YES	NO	Numbness or tingling	YES	NO	Trouble Sleeping	YES	NO	Headaches

8) Please mark where you have pain:



9) Please circle your pain level in past 24 hours:

0 1 2 3 4 5 6 7 8 9 10

10) What are your goals for therapy? _____

_____

_____ _____

Patient Signature Date Therapist Signature Date