

Current Condition(s)/Chief Compliant(s)

Describe the problem(s) for which you seek physical therapy: _____

When did the problem(s) begin (date)?

Month Year

What happened? _____

Have you ever had the problem(s) before?

Yes

What did you do for the problem(s)? _____

Did the problem(s) get better?

Yes No

No

How are you taking care of the problem(s) now? _____

What makes the problem(s) better? _____

What are your goals for physical therapy? _____

Are you seeing anyone else for the problem(s)? (Check all that apply)

- Acupuncturist Occupational therapist
- Cardiologist Orthopedist
- Chiropractor Dentist
- Pediatrician Podiatrist
- Nurse Practitioner Primary care physician
- Internist Rheumatologist
- Neurologist Obstetrician/gynecologist

Functional Status/Activity level (Check all that apply)

Difficulty with locomotion/movement:

- Bed mobility
- Transfers (such as moving from bed to chair, from bed to commode)
- Gait (walking)
 - On level On ramps
 - On stairs On uneven terrain

Difficulty with self-care (such as bathing, dressing, eating, toileting)

Difficulty with home management (such as household chores, shopping, driving/transportation, care of dependents)

Difficulty with community and work activities/integration

- Work/school
- Recreation or play activity

Are you aware of your diagnosis & prognosis as explained by your health provider? Yes No

Patient/Guardian Signature: _____

Date: _____

Medications

Do you take any prescription medications?

Yes No

Prednisone in the last year Yes No

Coumadin or other blood thinner Yes No

If yes please list:

Other Clinic Tests Within the past year, have you had any of the following tests? (Check all that apply)

- Angiogram Mammogram
- Arthroscopy MRI
- Biopsy Myelogram
- Blood tests NVC (nerve conduction)
- Bone scan Myelogram
- Bronchoscopy Pap smear
- CT scan Spinal tap
- Doppler ultrasound Stool tests
- Echocardiogram Stress test (treadmill)
- EEG Urine tests
- EKG X-rays
- EMG Other: _____



Name: _____

Health Care Provider: _____

Date of birth: _____

Are you: a. Right-handed b. Left-handed

Cultural/Religious: Any customs or religious or wishes that might affect care? _____

With whom do you live:

- Alone
- Spouse only
- Spouse and other(s)
- Child (not spouse)
- Other relative(s) (not spouse or children)
- Group setting
- Other:

Employment/Work (Job/School/Play)

- Working full-time outside of home
- Working full-time from home
- Working part-time outside of home
- Working part-time from home
- Homemaker
- Student
- Retired
- Unemployed

Occupation: _____

Living Environment

- | | |
|---|---|
| Does your home have: | Do you use: |
| <input type="checkbox"/> Stairs, no railing | <input type="checkbox"/> Cane/crutches |
| <input type="checkbox"/> Stairs, railing | <input type="checkbox"/> Walker |
| <input type="checkbox"/> Ramp | <input type="checkbox"/> Manual wheelchair |
| <input type="checkbox"/> Uneven terrain | <input type="checkbox"/> Motorized wheelchair |

General Health Status

- Please rate your health:
 Excellent Good Fair Poor
- Have you had any major life changes during the past year? (eg, new baby, job change, death of family member)
 Yes No

Social/Health Habits

- Currently smoke tobacco Yes No
- Exercise:
 Do you exercise beyond normal daily activities and chores?
 Yes Describe the exercise: _____
 On average, how many days per week do you exercise? _____
- No

Family History (Indicate whether mother, father, brother/sister or grandparents, age of onset if know)

- Heart disease: _____
- Hypertension: _____
- Stroke: _____
- Diabetes: _____
- Cancer: _____
- Arthritis: _____
- Osteoporosis: _____

Medical/Surgical History

Please check if you ever had:

- | | |
|--|---|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Multiple sclerosis |
| <input type="checkbox"/> Broken bones/fractures | <input type="checkbox"/> Muscular dystrophy |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Parkinson disease |
| <input type="checkbox"/> Blood disorders | <input type="checkbox"/> Seizures/epilepsy |
| <input type="checkbox"/> Circulation/vascular problems | <input type="checkbox"/> Development or growth problems |
| <input type="checkbox"/> Heart problems | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Lung problems | <input type="checkbox"/> Infectious disease (eg, tuberculosis, hepatitis) |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Kidney problems |
| <input type="checkbox"/> Diabetes/high blood sugar | <input type="checkbox"/> Repeated infections |
| <input type="checkbox"/> Low blood sugar/hypoglycemia | <input type="checkbox"/> Ulcers/stomach problems |
| <input type="checkbox"/> Pacemaker/Defib | <input type="checkbox"/> Skin diseases |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Other: _____ |

Within the past year, have you had any of the following symptoms? (Check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Difficulty sleeping |
| <input type="checkbox"/> Heart palpitations | # of hrs of sleep _____ |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Loss of appetite |
| <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Nausea/vomiting |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Difficulty swallowing |
| <input type="checkbox"/> Dizziness or blackouts | <input type="checkbox"/> Bowel problems |
| <input type="checkbox"/> Coordination problems | <input type="checkbox"/> Weight loss/gain |
| <input type="checkbox"/> Weakness arms or legs | <input type="checkbox"/> Urinary problems |
| <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Fever/chills/sweats |
| <input type="checkbox"/> Difficulty walking | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Joint pain or swelling | <input type="checkbox"/> Hearing problems |
| <input type="checkbox"/> Pain at night | <input type="checkbox"/> Vision problems |

Have you ever had surgery? Yes No
If yes, please describe and include dates:

For men only: Have you been diagnosed with prostate disease? Yes No

For women only: Pregnant or might be pregnant?
 Yes No