

PATIENT INFORMATION

Patient Name: _____

Patient #: _____

Date: _____

Have you had any falls in the past year?

Yes No

Are you? Right-handed

Left-handed

LIVING ENVIRONMENT – Does your home have?

Stairs with no railing

Stairs and railing

Ramps

Obstacles: _____

Uneven terrain

Elevator

Assistive devices (raised commode): _____

With whom do you live?

Alone

Spouse

Children

Parents

Other

How did you hear about us? _____

EMPLOYMENT / WORK (JOB/SCHOOL/PLAY)

Occupation: _____

Working full-time

Working part-time

Homemaker / Student

Retired

Unemployed

HEALTH HABITS

Smoking Currently: Yes No

Alcohol: Current

Past

Never

Do you exercise beyond normal, daily activities and chores?

Yes

No

MEDICAL / SURGICAL HISTORY

Please check if you have ever had (check all that apply):

Arthritis

Broken bones / fractures

Osteoporosis

Heart attack

Circulation / vascular problems

Heart problems

Stroke

High blood pressure

Lung problems

Head injury

Diabetes / high blood sugar

Hypoglycemia / low blood sugar

Parkinson's disease

Multiple Sclerosis

Allergies

Developmental or growth problems

Seizures or epilepsy

Latex allergy

Ulcers / stomach problems

Thyroid problems

Kidney problems

Skin diseases

Depression

Cancer

Infectious disease (e.g. tuberculosis, hepatitis)

Other: _____

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

Chest pain

Bowel problems

Urinary problems

Headaches

Shortness of breath

Dizziness or blackouts

Coordination problems

Weakness in arms or legs

Loss of balance

Difficulty walking

Joint pain or swelling

Pain at night

Difficulty sleeping

Loss of appetite

Fever / chills / sweats

Difficulty swallowing

Weight gain

Weight loss

Hearing problems

Vision problems

Other: _____

Please list any surgeries and include approximate dates (month/year):

_____/____/____ ____/____/____ ____/____/____

FOR MEN ONLY:

Have you been diagnosed with prostate disease?

Yes

No

FOR WOMEN ONLY:

Are you pregnant or think you might be pregnant?

Yes

No

Have you been diagnosed with other OB/GYN difficulties?

Yes

No

Have you ever had surgery related to women's health?

Yes

No

PATIENT INFORMATION

Patient Name: _____ Patient #: _____ Date: _____

CURRENT CONDITIONS / CHIEF COMPLAINTS

When did the problem(s) begin? (month/day/year) ____/____/____

What happened? _____

Have you ever had this problem before? Yes No

If yes: How long did the problem(s) last? _____

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

Did the problem get better? Yes No

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

What are your goals for physical therapy? _____

Are you seeing any healthcare providers for your current problem(s)? (please list) _____

MEDICATIONS

Do you take any medications? Yes (please list below, use back of page if necessary) No

Have you previously taken any medications for the condition for which you are seeing the physical therapist?

Yes No If yes, please list: _____

OTHER CLINICAL TESTS


- Angiogram (heart catheter)
- EKG (electrocardiogram)
- NCV (nerve conduction velocity)
- Other: _____
- Bone scan
- Mammogram
- X-rays
- CT scan
- MRI
- Stress test (e.g. tread mill, bicycle)

PAIN

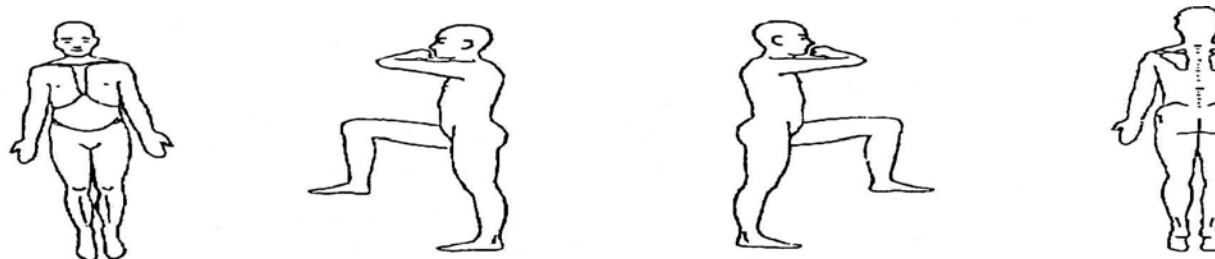
Please indicate your level of pain at this time by marking either the numerical or visual scale:

0 1 2 3 4 5 6 7 8 9 10

None Mild Moderate Severe Very Severe



NO HURT HURTS A LITTLE BIT HURTS A LITTLE MORE HURTS EVEN MORE HURTS A WHOLE LOT HURTS WORST



Please mark on the diagram above where you are having your symptoms / pain