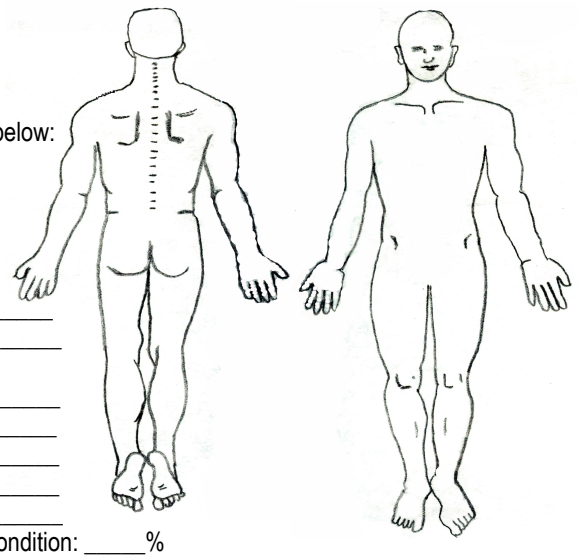
Name: _____ Date: _____

Current History:

1. What are your current complaints/symptoms that cause you to seek physical therapy? _____
_____
2. Please describe….
   A) When did this specific condition begin: _____
   B) When did your complaint/symptom begin: _____
   C) What happened to cause your current complaints/symptoms: _____
      a. If surgery please describe: _____
   D) Please describe the health care that you have received thus far for your condition? Please describe in chronological order these events such as ER visits, physician visits, home remedies and treatments from any health care provider leading up to your Physical Therapy visit?
   _____
   _____
   _____
   E) Please describe any other details of your story so we can best understand your condition: _____
   _____
3. If you have had any of the following testing for this condition, please circle all that apply and list facility where taken and date taken:
   A) X-Ray MRI CAT scan Bone Scan Other: _____ Facility/Date: _____
5. Please rate your current pain for this condition 0-10 with 0 being no pain to 10 being the worst pain:
   A) Current pain for this condition……. (0-10): _____
   B) At the best since this condition began…. (0-10): _____
   C) At the worst since this condition began… (0-10): _____

4. Please draw the location of your symptoms on the pictures to the right with the symbols below:
   Pins and Needles ^^^^ **Stabbing** ////
   Numbness o o o **Burning** x x x
   Ache **** **Other - - -**



Prior Level of Function:

1. What activities are you limited with that you want to return to: _____
_____
2. What is your work status prior to this condition? (Please circle)
   Full time, Part time, Light Duty, Retired, Homemaker, Unemployed, Disabled, Other: _____
   A) What are your description of duties/responsibilities and your job title: _____
   _____
   _____
   B) If employed, who is your employer: _____
3. Please rate at what percent 0-100% that you were able to function prior to your current condition: _____%
4. Have you fallen in the past year? Yes / No If yes, were you injured in the process of falling? Yes / No

Current Level of Function:

1. Please rate at what percent 0-100% that you are able to function due to your current condition: _____%
2. What is your biggest limitation resulting from your condition? _____
3. What is your work status prior to this condition? (Please circle)
   Full time, Part time, Light Duty, Retired, Homemaker, Unemployed, Disabled, Other: _____
4. How often do you exercise? Never 1X/week 2X/week 3X/week 4x or more/week

Goals:

1. What would you like to achieve with physical therapy? _____
_____

Social History (please circle)

1. Do you live with anyone: YES NO If yes…please list: _____
2. Living Environment: One Story Two Story Apartment Number of stairs to enter: ___ Railing: YES NO If yes…Is it on L or R or BOTH
   A) If TWO Story…Number of stairs to 2nd level: ____ Bedroom on 1st or 2nd floor: ____ Bathroom on 1st or 2nd floor or BOTH: _____
3. Do you own: Cane Walker Wheelchair Other: _____ AND Do you use: Cane Walker Wheelchair Other: _____

More on back➔

Medical History:

1. Who is your primary care/family doctor: _____ Date of last visit: _____
2. Please list any surgeries or other reasons for hospitalization with approximate dates: _____

_____

3. Please list below all current PRESCRIPTION medication AND Over The Counter (OTC) medications and Vitamins prescribed and nonprescription

MEDICATIONS and VITAMINS	DOSAGE	FREQ.	Mode of delivery	MEDICATIONS and VITAMINS	DOSAGE	FREQ.	Mode of delivery
1.				6.			
2.				7.			
3.				8.			
4.				9.			
5.				10.			

Have you or any member of your family EVER been diagnosed with any of the following, if **YES please CIRCLE "SELF" or "FAMILY"**.

Cancer	YES	NO	SELF / FAMILY	Other Arthritis Condition	YES	NO	SELF / FAMILY
Heart Attack	YES	NO	SELF / FAMILY	Gout	YES	NO	SELF / FAMILY
Atherosclerotic Disease	YES	NO	SELF / FAMILY	Fibromyalgia	YES	NO	SELF / FAMILY
Heart Murmur	YES	NO	SELF / FAMILY	Depression	YES	NO	SELF / FAMILY
Pacemaker	YES	NO	SELF / FAMILY	Hepatitis	YES	NO	SELF / FAMILY
High Blood Pressure	YES	NO	SELF / FAMILY	Tuberculosis	YES	NO	SELF / FAMILY
Low Blood Pressure	YES	NO	SELF / FAMILY	Stroke	YES	NO	SELF / FAMILY
COPD	YES	NO	SELF / FAMILY	Kidney Disease	YES	NO	SELF / FAMILY
Asthma	YES	NO	SELF / FAMILY	Anemia	YES	NO	SELF / FAMILY
Emphysema	YES	NO	SELF / FAMILY	Epilepsy	YES	NO	SELF / FAMILY
Chemical Dependency	YES	NO	SELF / FAMILY	Hearing Loss	YES	NO	SELF / FAMILY
Thyroid problems	YES	NO	SELF / FAMILY	Seizures	YES	NO	SELF / FAMILY
Diabetes (Type I, II)	YES	NO	SELF / FAMILY	Allergies or Sensitivities	YES	NO	SELF / FAMILY
Multiple Sclerosis	YES	NO	SELF / FAMILY	High Cholesterol	YES	NO	SELF / FAMILY
Rheumatoid Arthritis	YES	NO	SELF / FAMILY	Other _____			

Review of Systems:

Have you had or do you currently experience: (please check YES or NO)

A) Cardiovascular System:	YES	NO
Elevated cholesterol	____	____
Sweating associated with pain	____	____
Palpitations	____	____
Swelling of extremities	____	____
History of Smoking	____	____
Orthopnea (difficulty breathing)	____	____

B) G.I. System:	YES	NO		YES	NO
Difficulty swallowing	____	____	Change in color of stool	____	____
Heartburn	____	____	Rectal bleeding	____	____
Jaundice (yellow appearance)	____	____	Gall bladder problems	____	____
Specific food intolerance	____	____	Liver problems	____	____
Constipation	____	____			
Diarrhea	____	____			

C) Pulmonary System:	YES	NO
Dyspnea (labored breathing)	____	____
Wheezing	____	____
Prolonged cough	____	____
Sputum production	____	____
-Amount: _____		
-Color: _____		

D) G.U. System	YES	NO		YES	NO
Dysuria (painful urination)	____	____	Vaginal discharge	____	____
Hematuria (blood in urine)	____	____	Dysmenorrhea (painful menstration)	____	____
Frequency of urination	____	____			
Urinary urgency	____	____	Post-menopausal vaginal bleeding	____	____
Incontinence	____	____			
Painful intercourse	____	____	Date of Last period: _____		
Infertility	____	____			
History of STD	____	____			

E) Neurological Systems:	YES	NO
Ataxia	____	____
Memory lapses	____	____
Confusion	____	____
Head Trauma	____	____
Neurological disorder	____	____
Tremors	____	____
Slurred speech patterns	____	____
Hearing/Visual disturbances	____	____

F) Endocrine System:	YES	NO		YES	NO
Excessive thirst	____	____	Excessive hunger	____	____
Polyuria (large volume of urine)	____	____	Excessive sweating	____	____
Fatigue	____	____	Weakness	____	____
Thyroid problems	____	____			

G) Other	YES	NO		YES	NO
Ears, Nose, Throat	____	____	Integumentary (skin)	____	____
Lymphatic	____	____	Psychiatric	____	____
Musculoskeletal	____	____			

Height_____ Weight_____