Name: ____ Height: ____________ Weight: __________________

Medical History:

1. Have you been diagnosed with any of the following, if **YES please CIRCLE**

Allergies	Concussion	Heart Attack	Multiple Sclerosis	Spinal Stenosis
Allergic to latex	COPD	Heart Disease	Neurological Issues	Stroke/TIA
Amputation	Coronary heart disease	Hernia	Osteoarthritis	Thyroid
Anemia	Depression	High Blood Pressure	Osteoporosis	Tobacco Use
Angina	Diabetes, type 1	Incontinence	Oxygen Dependency	Torticollis
Ataxia	Diabetes, type 2	Infectious Disease	Pacemaker	Varicose Veins
Bell 's palsy	Dizziness or faintness	Intractable Pain	Parkinson's Disease	Vasculitis
Blood Clot/Emboli	Drink alcohol	Kidney Disease	Pelvic floor issue(s)	Vertigo/Balance
Bowel/bladder problems	Emphysema	Lipedema	Pneumonia	Vision Difficulties
Bronchitis	Energy loss	Low Blood Sugar	Pregnancy, current	Weakness
Cancer	Epilepsy/Seizures	Lumpectomy	Rheumatoid arthritis	Weight loss
Carpal tunnel syndrome	Epstein-Barre Syndrome	Lupus	Sciatica	Women's health
Cellulitis	Headaches, severe	Lyme Disease	Shortness of Breath	Other surgery
Cerebral Palsy	Hearing difficultly	Lymphedema	Sleep Apnea	Other important
Complex Regional Pain Syndrome		Mastectomy	Sleeping Problems	_______________

2. Do you have?

___ Joint replacement if so, what body part? _________ ___ Numbness if so, what body part? __________
___ Pins or metal implant if so, what body part? _________ ___ Tingling/neuropathy if so, what body part? __________
___ Arthritis if so, what body part? __________

Social History (please circle)

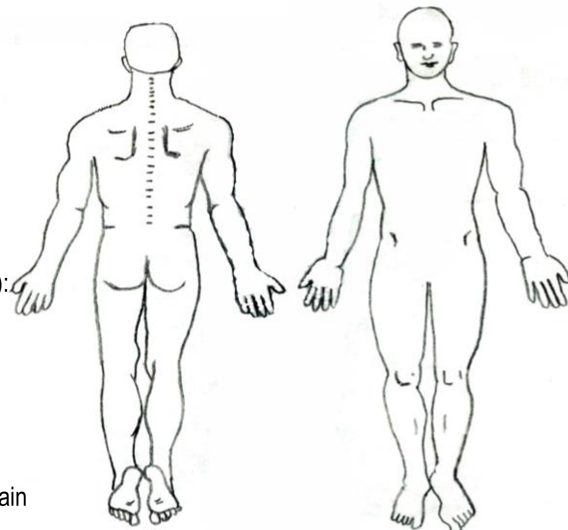
1. Do you live with anyone: YES NO Are you a caregiver for someone else: YES NO
2. Living Environment: One Story or Two Story
3. Do you use: Cane Walker Wheelchair Other: ________
4. Did you receive home health PT for this current condition? YES NO

Current Level of Function:

1. Does your diagnosis impact your ability to work/?
   ___ Not applicable
   ___ I am retired
   ___ The diagnosis prevents me from working
   ___ I can only work part time
   ___ I can work, but with minor difficulty
   ___ I can work, but with great difficulty
   ___ This diagnosis does not impact my ability to work

Does your diagnosis impact your ability to attend school?
   ___ Not applicable
   ___ The diagnosis prevents me from attending school
   ___ I am in school, and the diagnosis has a big impact
   ___ I am in school, and the diagnosis has a minor impact
   ___ School is normal, but I cannot participate in sports
   ___ School is normal, no impact

2. How often do you exercise? Never 1X/week 2X/week 3X/week 4x or more/week
3. Does your daily routine, or work aggravate your injury?
   ___ No
   ___ I am unable to participate in my normal routine or work
   ___ My routine/work usually impacts my injury 1 day a week
   ___ My routine work usually impacts my injury about 2 days a week
   ___ My roune/work usually impacts my injury about 3 or more days a week
   ___ My routine/work usually impacts my injury every day, but I try to cope



Current History:

1. Is your pain/condition due to a prior injury? ______ If yes, what year? ________
2. Please rate your current pain/severity for this condition 0-10 (0 is no pain to 10 is 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): __________________
3. Please draw the location of your symptoms on the pictures to the right with the symbols below:

Aching *****	Dull D D D	Throbbing # # #	Deep - - -
Burning X X X	Heavy H H H	Variable ~ ~	Stabbing ////
Constant C C C	Numb Z Z Z	Weak w w w	I do not have any pain
Cramping R R R	Pins/ needles ^^^		

4. **What makes your pain/condition worse? (Please check all that apply.)**
   ___ Reaching back ___ Lying flat ___ Getting out of bed
   ___ Dressing/Grooming ___ Cooking ___ Carrying items
   ___ Climbing Stairs ___Twisting ___ Lifting anything
   ___ Lifting heavy weights ___ Pulling ___ Raising arm overhead
   ___ Looking up/down ___ Walking

What relieves your pain? (Please check all that apply)
   ___ Ice ___ Heat ___ Stretching
   ___ Exercise ___ Pain meds ___ Lying Flat
   ___ Avoiding activity ___ Nothing

5. Have you fallen in the past year? Yes / No If yes, were you injured in the process of falling? Yes / No
6. Do you currently: (Check all that apply): ___ Smoke Tobacco ___Chew Tobacco ___ Snuff Tobacco
7. Have you ever received advice or counseling to help you stop using tobacco? ___ Yes ___ No

OVER→

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.			