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? ________________________________

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: ________________________________

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? 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: _____%

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 after this condition? Full time, Part time, Light Duty, Retired, Homemaker, Unemployed, Disabled, Other: ____________

Goals:

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

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: ________________________________

Review of Systems:

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

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

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	____	____	History of STD	____	____
Painful intercourse	____	____	Date of Last period: _______________		
Infertility	____	____			

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

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
Integumentary (skin)	____	____
Psychiatric	____	____