Name: _____ Date: _____

Current History:

1. What are your current chief complaints or symptoms that cause you to seek physical therapy? _____
   _____
2. When did your current complaints or symptoms begin? _____
3. What happened to cause your current complaints or symptoms: (i.e., I had a stroke, I was in a car accident, I fell, I had surgery, etc.): _____
   _____
4. Please describe in chronological order the health care that you have received for this condition, such as ER visits, physician visits, injections, home remedies, or any other health care leading up to your physical therapy visit. _____
   _____
   _____
5. Have you had any of the following testing for this condition? (circle all that apply):
   A) ☐ X-Ray MRI ☐ CAT Scan ☐ Bone Scan ☐ Other: _____ Facility where they were taken and when: _____

Prior Level of Function:

1. What activities did you enjoy or take part in ***prior to when your symptoms began***? _____
2. What was your employment status ***prior to when your symptoms began?*** (☐ Employed or ☐ Unemployed; ☐ Full-time or ☐ Part -time)
   A) If employed, who was/ is your employer? _____
   B) If employed, what was/ is your job title and duties _____
3. Please rate at what percent 0-100% that you were able to function ***prior*** to your current condition (0-100%): _____%

Current Functional Status:

1. Please rate your ***current*** level of function due to your current condition (0-100%): _____%
2. What are your ***current*** and biggest limitations due to your current condition? _____
   _____
3. What is your ***current*** work status? Please Circle (☐ Full-time, ☐ Part-time, ☐ Light/Modified Duty, ☐ Off work, ☐ Retired, ☐ Disabled)

Goals:

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

Medical History and Review of Systems:

1. Who is your primary care/family doctor: _____ Date of last visit: _____
2. Please list any past surgeries or other reasons for hospitalization that may affect your physical therapy care, with approximate dates _____
   _____
3. Please list major medical conditions that immediate family member has been diagnosed with: (i.e., heart attack, stroke, MS, diabetes, cancer, etc.)
   _____
   _____

Review of Systems:

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

A) Cardiovascular System:	**YES**	**NO**
Elevated Cholesterol	☐	☐
Palpitations	☐	☐
Sweating with pain	☐	☐
History of Smoking	☐	☐
Difficulty Breathing	☐	☐

B) Pulmonary System:	**YES**	**NO**
Dyspnea (labored breathing)	☐	☐
Wheezing	☐	☐
Prolonged Cough	☐	☐
Sputum Production	☐	☐

C) Neurological Systems:	**YES**	**NO**
Head Trauma	☐	☐
Slurred Speech	☐	☐
Hearing/Visual Disturbances	☐	☐
Confusion/Memory Loss	☐	☐
Ataxia/Balance trouble	☐	☐
Tremors	☐	☐
Multiple Sclerosis	☐	☐
Stroke	☐	☐
Other Neurological disorder	☐	☐

D) G.I. System:	**YES**	**NO**
Difficulty Swallowing	☐	☐
Heartburn	☐	☐
Food Intolerance	☐	☐
Constipation	☐	☐
Diarrhea	☐	☐
Rectal Bleeding	☐	☐
Liver problems	☐	☐
Gall bladder problems	☐	☐

E) G.U. System:	**YES**	**NO**
Dysuria(painful urination)	☐	☐
Blood in Urine	☐	☐
Frequency of urination	☐	☐
Urinary urgency	☐	☐
Incontinence	☐	☐
Painful intercourse	☐	☐
Infertility	☐	☐
Vaginal discharge	☐	☐
Painful menstruation	☐	☐
Post-menopausal bleeding	☐	☐
History of STD	☐	☐
Date of Last period:	☐	☐

F) Endocrine System:	**YES**	**NO**
Excessive Thirst	☐	☐
Fatigue	☐	☐
Thyroid problems	☐	☐
Excessive hunger	☐	☐
Excessive sweating	☐	☐
Weakness	☐	☐
Polyuria (large amts of urine)	☐	☐

G) Other:	**YES**	**NO**
Ears, Nose, Throat	☐	☐
Dizziness	☐	☐
Vertigo	☐	☐
Concussion	☐	☐
Lymphatic	☐	☐
Musculoskeletal	☐	☐
Integumentary	☐	☐
Psychiatric	☐	☐
Depression	☐	☐
Allergies	☐	☐
Falls	☐	☐
Unexplained Weight Loss	☐	☐
Loss of Balance	☐	☐