**Patient Name:**_____ **Date:**_____

## Information About the Problem You Are Attending Physical Therapy For Today

**When did your <u>current</u> symptoms begin?** _____

**If you don't know the specific date, how long have they been present?**

- ❑ No. of weeks: _____
- ❑ No. of months: _____
- ❑ No. of years: _____
- ❑ unsure
- ❑ they come and go throughout the year
- ❑ No. of episodes/year: _____

**How did your symptoms start? (please choose <u>ONE</u> answer that is most accurate)**

- ❑ a motor vehicle accident
- ❑ a work related injury/accident
- ❑ surgery
- ❑ a bike accident
- ❑ a slip and fall
- ❑ an increase in exercise
- ❑ due to an injury
- ❑ gradually, change in activity may be cause
- ❑ gradually, unsure of cause
- ❑ gradually due to:_____
- ❑ suddenly, during:_____
- ❑ suddenly, after:_____
- ❑ suddenly, for no apparent reason

**If you had an injury, describe the details of how it happened:** _____

_____

_____

**If you have had a previous episode of similar symptoms, please describe:** _____

_____

**If you had surgery, on what date was it performed?** _____

**Since the start of your symptoms, how have they changed?**

❑ unchanging ❑ worsening ❑ improving ❑ Comment: _____

**<u>Relative to the problem you are seeking care for today</u>, please select <u>all</u> the symptoms you are having:**

- ❑ Pain
- ❑ Pins and needles
- ❑ Numbness
- ❑ Burning sensation
- ❑ Stiffness
- ❑ Cramping
- ❑ Swelling
- ❑ Giving way
- ❑ Joint Locking
- ❑ Instability
- ❑ Weakness
- ❑ Dizziness
- ❑ Balance Loss
- ❑ Unsteadiness with walking
- ❑ Other: _____
  _____

**<u>Relative to the problem you are seeking care for today</u>, where are your symptoms located?**

**Affected Side:** ❑ Left ❑ Right ❑ Both

- ❑ neck
- ❑ low back
- ❑ arm
- ❑ shoulder blade
- ❑ shoulder
- ❑ upper arm
- ❑ elbow
- ❑ forearm
- ❑ wrist
- ❑ hand
- ❑ thumb
- ❑ headache
- ❑ between shoulder blades
- ❑ middle back
- ❑ ribs
- ❑ leg
- ❑ hip
- ❑ buttock
- ❑ groin region
- ❑ front of thigh
- ❑ back of thigh
- ❑ outside of thigh
- ❑ knee
- ❑ shin
- ❑ calf
- ❑ ankle
- ❑ foot
- ❑ great toe
- ❑ toes
- ❑ Other:_____
  _____

**What brings on your symptoms or makes them worse?**

| | | | |
|---|---|---|---|
| ❑ sitting | ❑ coughing/sneezing | ❑ transfer positions | ❑ pivoting |
| ❑ bending | ❑ inhaling/exhaling | ❑ rolling in bed | ❑ driving |
| ❑ standing | ❑ reading | ❑ weight bearing | ❑ nothing I know of |
| ❑ walking | ❑ using computer | ❑ lifting | ❑ everything |
| ❑ stairs | ❑ lying down | ❑ reaching | ❑ Other:_____ |

**What can you do to reduce your symptoms?**

| | | | |
|---|---|---|---|
| ❑ resting | ❑ walking | ❑ exercise | ❑ applying heat |
| ❑ laying down | ❑ sitting | ❑ medication | ❑ nothing relieves symptoms |
| ❑ standing | ❑ bending over | ❑ applying ice | ❑ Comment:_____ |

**Previously, what treatments were effective at improving your symptoms?**

| | | | |
|---|---|---|---|
| ❑ Physical therapy | ❑ Bracing | ❑ Medication | ❑ Limiting Activities |
| ❑ Acupuncture | ❑ Massage therapy | ❑ Rest | ❑ Other:_____ |
| ❑ Chiropractic | ❑ Injection | ❑ Ice Heat | _____ |

**Previously, what treatments did you try that did not help your symptoms?**

| | | | |
|---|---|---|---|
| ❑ Physical therapy | ❑ Bracing | ❑ Medication | ❑ Limiting Activities |
| ❑ Acupuncture | ❑ Massage therapy | ❑ Rest | ❑ Other:_____ |
| ❑ Chiropractic | ❑ Injection | ❑ Ice Heat | _____ |

## Medical History

**Do you currently have any of the following problems? (Check all that apply)**

| | | |
|---|---|---|
| ❑ abdominal pain | ❑ fever/chills/sweats | ❑ numbness or changes in sensation |
| ❑ anxiety | ❑ foot pain/discoloration | ❑ pain at night |
| ❑ bowel problems | ❑ frequent heartburn or indigestion | ❑ pain or cramping in lower leg (calf) |
| ❑ chest pain | ❑ frequent or severe headaches | ❑ prolonged fatigue |
| ❑ coordination problems | ❑ hearing problems | ❑ seizures |
| ❑ cough that is chronic | ❑ heart palpitations | ❑ sexually transmitted disease |
| ❑ difficulty or changes in swallowing | ❑ hoarseness or changes in speech | ❑ shortness of breath |
| ❑ difficulty sleeping | ❑ insomnia | ❑ stress/tension |
| ❑ difficulty walking | ❑ loss of appetite | ❑ unusual lumps or growths |
| ❑ dizziness or blackouts | ❑ loss of balance or falling | ❑ unusual menstrual irregularities |
| ❑ fainting spells | ❑ loss of pleasure in things usually enjoyed | ❑ urinary problems |
| ❑ feeling downhearted or blue | ❑ nausea or vomiting | ❑ vision problems (blurred vision or loss of sight) |
| ❑ weakness in arms or legs | ❑ Other: _____ | |

**Has your weight changed significantly recently?**

❑ no ❑ increased ❑ decreased ❑ **If so, how much?** _____ lbs. **Over what type of time frame?** _____

**What is the reason for your weight change?**

❑ unknown ❑ illness ❑ dieting ❑ eating healthy/exercise ❑ inactivity

**What conditions have you been diagnosed with?**

- ❑ Alzheimer's disease
- ❑ arthritis
- ❑ asthma
- ❑ blood disorders
- ❑ broken bones/fractures
- ❑ cancer
- ❑ COPD
- ❑ deep vein thrombosis or pulmonary embolism
- ❑ depression
- ❑ developmental or growth problems
- ❑ diabetes Type 1
- ❑ diabetes Type 2
- ❑ eating disorder
- ❑ emphysema
- ❑ fibromyalgia
- ❑ GERD or reflux
- ❑ gout
- ❑ head injury
- ❑ heart attack/MI
- ❑ heart disease
- ❑ hearing impairment
- ❑ hypercholesteremia (high cholesterol)
- ❑ hypertension (high blood pressure)
- ❑ infectious disease (i.e. hepatitis)
- ❑ kidney disease
- ❑ liver disease
- ❑ low blood pressure
- ❑ multiple sclerosis (MS)
- ❑ muscular dystrophy (MD)
- ❑ obesity
- ❑ osteoarthritis
- ❑ osteoporosis
- ❑ Parkinson disease
- ❑ peripheral neuropathy
- ❑ psychiatric disorders
- ❑ repeated infections
- ❑ seizures or epilepsy
- ❑ spinal cord injury
- ❑ skin diseases
- ❑ stomach problems or ulcers
- ❑ stroke
- ❑ thyroid disease
- ❑ vision impairment
- ❑ other joint injuries please list: _____
- ❑ other: _____

**Have you undergone any previous surgical procedures? (Please include date of procedure if you can)**

- ❑ No previous surgery
- ❑ ACL repair/reconstruction
- ❑ Achilles tendon repair
- ❑ Angioplasty
- ❑ Aortic Valve surgery
- ❑ Appendectomy
- ❑ Arthroscopic Surgery: _____
- ❑ Back surgery
- ❑ Bariatric surgery
- ❑ Bone marrow transplant
- ❑ Bunionectomy
- ❑ Coronary artery bypass graft
- ❑ Caesarian section
- ❑ Prostate surgery
- ❑ Cardiac catheterization
- ❑ Cardiac surgery
- ❑ Carpal tunnel release
- ❑ Cholecystectomy (gallbladder removed)
- ❑ Chondroplasty
- ❑ Colon surgery
- ❑ Colostomy
- ❑ Epidural injection
- ❑ Femoral popliteal bypass
- ❑ Hand surgery
- ❑ Heart transplant
- ❑ Hernia Repair
- ❑ Hysterectomy
- ❑ Joint Replacement: _____
- ❑ Kidney Transplant
- ❑ Liver Transplant
- ❑ Lung Surgery
- ❑ Lung Transplant
- ❑ Lumpectomy
- ❑ Mastectomy
- ❑ Neck surgery
- ❑ Pacemaker/Defibrillator
- ❑ Plastic surgery
- ❑ Rotator cuff repair
- ❑ Splenectomy
- ❑ Tracheostomy
- ❑ Other: _____

**What diagnostic testing have you had?**

- ❑ angiogram
- ❑ blood work
- ❑ bone scan
- ❑ CT scan
- ❑ colonoscopy
- ❑ doppler ultrasound
- ❑ echocardiaogram
- ❑ EEG (electroencephalogram)
- ❑ EKG (electrocardiogram)
- ❑ EMG (electromyogram)
- ❑ local steroid injection
- ❑ mammogram
- ❑ MRI
- ❑ myelogram
- ❑ NCV (nerve conduction velocity)
- ❑ pap smear
- ❑ pulmonary function test
- ❑ spinal tap
- ❑ stress test
- ❑ urine test
- ❑ X-Ray

**Please list any allergies:**

❑ Latex ❑ Dust mites ❑ Animal dander ❑ Cockroaches
❑ Pollen ❑ Mold ❑ Insect stings
❑ Fragrance (please specify): _____
❑ Food (please specify): _____
❑ Medications (please specify): _____
❑ Other: _____

## Health Behaviors

**Please rate your general health:**

❑ Excellent ❑ Very good ❑ Good ❑ Fair ❑ Poor

**Do you smoke?** ❑ Yes ❑ No **If so, how much do you smoke?**

❑ Not every day ❑ <1 pack per week ❑ 1-2 packs per week
❑ ____ cigarettes per day ❑ 1 pack per week ❑ 2-3 packs per week

**Do you exercise beyond normal daily activities?** ❑Yes ❑No **If so, what exercise do you do?**

❑ cardio and weight training at gym/home ❑ yoga ❑ sports
❑ exercise classes ❑ running ❑ swimming
❑ walking ❑ cycling ❑ rowing
❑ Other:_____

**If so, on *average*, how may days do you exercise or do physical activity?**

❑ Daily ❑ ____ times per week ❑ Other: _____

***On average*, how much time do you exercise or do physical activity each session?**

❑ 15-20 min ❑ 30 min ❑ 45 min ❑ 60 min ❑ Other:_____

**How many hours of undisturbed sleep do you get per night?**

❑ <1 hour ❑ 1-3 hours ❑ 3-4 hours ❑ 4-5 hours ❑ 5-6 hours ❑ 6-7 hours ❑ 7-8 hours ❑ >8 hours

## Fall History

**How many times have you fallen over the past year?**

❑ None ❑ 1 ❑ 2 ❑ 3 ❑ >3 ❑ >10 ❑ Number: _____ ❑ Unable to Remember

**What caused your fall?**

❑ lost balance ❑ seizure ❑ someone/something pushed you ❑ tripped
❑ dizziness ❑ sudden paralysis ❑ unsure

**Have you had a fall that resulted in an injury over the last year?**

❑ Yes ❑ None ❑ Unable to remember

## Work Status

**What is your present work status?**

- ❑ Homemaker
- ❑ Not employed/not seeking work
- ❑ On disability unrelated to this problem
- ❑ On disability due to this problem
- ❑ Retired
- ❑ Student
- ❑ Unable to work due to injury
- ❑ Unemployed, seeking work
- ❑ Working full duty, without restrictions
- ❑ Working with modified restrictions

**What is your occupation?** _____

**Who is your employer?** _____

**Describe what percentage of the day at work you do each of the following activities?**

| Activity | % Day | Varies day to day | Occasionally |
|---|---|---|---|
| Standing | | ❑ | ❑ |
| Sitting | | ❑ | ❑ |
| Walking | | ❑ | ❑ |
| Lifting or manipulating light objects 5-10#s | | ❑ | ❑ |
| Lifting or manipulating heavy objects >10#s | | ❑ | ❑ |
| Using a computer/tablet | | ❑ | ❑ |
| Deskwork including writing | | ❑ | ❑ |
| Defending myself and others | | ❑ | ❑ |
| Climbing (stairs or other) | | ❑ | ❑ |
| Driving | | ❑ | ❑ |
| Other_____ | | ❑ | ❑ |

## Goals for Physical Therapy

**What are your goals for physical therapy? (Check as many as apply to you)**

- ❑ Reduce pain:
  - ❑ To make things easier to do
  - ❑ To reduce or stop taking medication
  - ❑ To return to my previous activities
- ❑ Prevent re-injury or recurrence of problem
- ❑ Learn how to manage this problem in the future
- ❑ Improve independence with self-care activities:
  - ❑ bathing/showering
  - ❑ making a meal
  - ❑ grooming
  - ❑ light housekeeping
  - ❑ toileting
  - ❑ dressing
  - ❑ feeding
  - ❑ walking
- ❑ Return to doing house hold tasks/family roles:
  - ❑ washing dishes
  - ❑ making a bed
  - ❑ picking up groceries
  - ❑ caring for children
  - ❑ laundry
  - ❑ vacuuming
  - ❑ light cleaning
  - ❑ climbing stairs
  - ❑ making a meal
  - ❑ cleaning floors
  - ❑ taking out the trash
- ❑ Return to doing yardwork:
  - ❑ shoveling
  - ❑ weeding
  - ❑ snowblowing
  - ❑ gardening
  - ❑ cutting grass
  - ❑ carrying heavier items
- ❑ Return to light-duty work
- ❑ Return to full-duty work
- ❑ Return to exercise/hobbies:
- ❑ Return to athletics and sports: