Patient Name:_____ **Date:**_____

MEDICAL HISTORY

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

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

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
- ❑ vision impairment
- ❑ 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
- ❑ 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
- ❑ 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
- ❑ Prostate surgery
- ❑ 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
- ❑ ____ cigarettes per day
- ❑ <1 pack per week
- ❑ 1 pack per week
- ❑ 1-2 packs 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
- ❑ exercise classes
- ❑ walking
- ❑ yoga
- ❑ running
- ❑ cycling
- ❑ sports
- ❑ swimming
- ❑ 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

❑ Return to full duty

❑ Return to exercise/hobbies:

❑ Weightlifting	❑ Exercise classes	❑ Swimming	❑ Playing musical instrument/s
❑ Walking	❑ Yoga	❑ Rowing	
❑ Running	❑ Cycling	❑ Personal training	

❑ Return to athletics and sports:

❑ golf	❑ volleyball	❑ kickball	❑ swimming
❑ tennis	❑ hockey	❑ pickleball	❑ gymnastics
❑ soccer	❑ track	❑ paddle tennis	❑ dancing
❑ football	❑ baseball	❑ sailing	❑ other: _____
❑ lacrosse	❑ softball	❑ rowing	

Please select <u>all</u> the symptoms you are having:

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

Where are your symptoms located? **Affected Side:** ❑ Left ❑ Right ❑ Both

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

What brings on your symptoms or makes them worse?

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

What can you do to reduce your symptoms?

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

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

❑ unchanging ❑ worsening ❑ improving ❑ Comment: _____

How did your symptoms start? (choose one 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: _____

_____

_____

What was the date of your injury? _____

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: _____

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

_____

Previously, what treatments were effective at resolving your symptoms?

- ❑ physical therapy
- ❑ acupuncture
- ❑ chiropractor
- ❑ specialist MD
- ❑ massage therapist
- ❑ primary care group
- ❑ medication
- ❑ rest
- ❑ ice
- ❑ heat
- ❑ limiting activities
- ❑ Other _____

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

- ❑ physical therapy
- ❑ acupuncture
- ❑ chiropractor
- ❑ specialist MD
- ❑ massage therapist
- ❑ primary care group
- ❑ medication
- ❑ rest
- ❑ ice
- ❑ heat
- ❑ limiting activities
- ❑ Other _____