Patient Name:______________________________ Date:________________

Information About the Problem You Are Attending Physical Therapy For Today

When did your current 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 ONE 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: ______________________________________

Relative to the problem you are seeking care for today, please select all 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: ___________________________
____

Relative to the problem you are seeking care for today, 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
- ❑ 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 ❑ <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: