Please Answer All Questions, Front and Back Sides

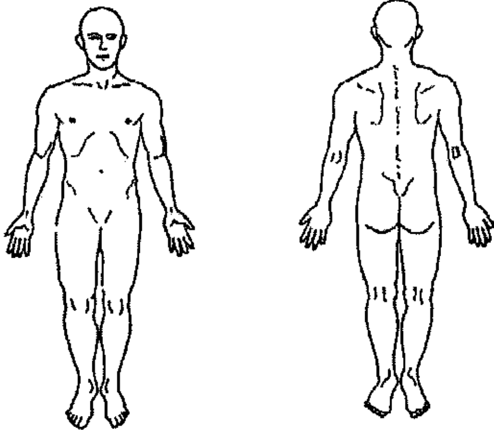
History of Current Condition

Name:______________________________
Date of Birth:__________________________
Today's Date:__________________________
Who referred you:______________________
Primary Doctor:_______________________
Are you being treated by another professional for this condition? __No __Yes:
Who:______________________________
Have you received physical therapy for this condition before? __No __Yes:
Where:_____________________________
What are your primary complaints?
1.________________________________
2.________________________________

Date of injury: (mm/dd/yy)______________
Onset of symptoms __Sudden __Gradual
How did it occur:_______________________
____

Have you had any prior episodes: __No __Yes

Please mark all areas of pain/abnormal sensation



Describe your Pain:
__Aching __Burning __Stabbing
__Pins/Needles __Dull __Sharp
Rate your pain: ___/10 *(0 being low, 10 being high)*
Pain is worse in:
__Morning __Afternoon __Night
Frequency of Pain:
__0-25% __26-50% __51-75% __76-100%
Check if you have pain/difficulty with any of the following:
__Walking __Standing __Reaching
__Sitting __Bending __Stairs
__Lying down __Sleeping

Mandated by your insurance company, please write down and score 3 activities/functional tasks you are having difficulty with and would like to improve in PT (0=Unable to do, 10= No difficulty):
1.______________________________ __/10
2.______________________________ __/10
3.______________________________ __/10
What relieves your Pain/Symptoms?:
__Rest __Ice __Heat __Medication
__Movement:___________________________
__Nothing
__Other:______________________________
____

Medical History

Check if you are currently experiencing/have had experienced any of the following:

__Heart attack __Stroke
__High Blood Pressure: ___/___ mmHg
__Bowel/Bladder problems __Pacemaker
__Cancer __Seizures
__Fatigue __Diabetes
__Chronic Fatigue Syndrome __Dizziness
__Headaches __Hernia
__Head Trauma/Concussion __Depression
__Anxiety __Asthma
__Unexplained weight loss __Jaw Pain
__ Fibromayalgia __TB, AIDS, Hepatitis
__Difficulty taking a deep breath
__Pregnancies:___ When:________________
__Recent Falls:___ When:________________
__Other:______________________________
____

Injuries/Surgeries/Tests

Please list all major injuries:_________________
____
____
Please list any other medical conditions you may have:________________________________
____
____
Please list all surgeries:____________________
____
____
Have you had any tests/images done for your condition? __No __Yes: __X-ray __MRI __CT Scan __Bone Scan __EMG __Other

____

OVER >>>>>>>>>

Living Environment

__Live Alone __Live with others
__Have help at home __Caretaker to others
__Stairs into home __Stairs in home

Does your living environment negatively affect your pain/condition? __No __Yes:
Explain:____________________

Do you perform any of the following:
__Housework __Yardwork __Shoveling snow

Does your condition make tasks at home difficult?
__No __Yes

Work Environment

Occupation:____________________
__Full time __Part time __Student
__Unemployed __Other:____________

Does your work require: __Sitting __Standing
__Walking __Climbing __Kneeling __Filing
__Stairs __Carrying __Twisting __Bending over
__Pushing/Pulling __Reaching
__Other:____________________
__Typing (Desk is ergonomic:__No __Yes)
__Phone use (Head set/Speaker use:__No __Yes)

Do any of the above tasks make pain/condition worse? __No __Yes:
Explain____________________

Have you had to take any time off of work due to your condition? __No __Yes

General Health

Do you exercise regularly? __No __Yes:
Please List Exercises:____________________
____

Does your condition affect your exercise program?
__No __Yes:
Explain:____________________

Previous Functional Level:
__Independent in all activities
__Independent in all self care activities
__Difficulty performing self care activities
__Assistance needed for self care activities
__Difficulty with household activities
__Difficulty with activities at home and in Community

Are you interested in learning more about:
__Pilates __Yoga __Functional Based Exercise
__Body Mechanics

Medication List

Please provide an attached sheet or list your current medications with name, dose and frequency:

____
____
____
____
____
____

Allergies

Do you have any allergies to tape or adhesive?
__No __Yes

Do you have any allergies to latex, rubber, sulfites, coconut, beeswax, other?
__No __Yes:____________________

Goals

What are your goals for Physical Therapy?
1.____________________
2.____________________
3.____________________

Rate how your current pain/condition/injury affects your:

Home Life:	Mild	Moderate	Severe
Work:	Mild	Moderate	Severe
Personal Life:	Mild	Moderate	Severe
Stress Level:	Mild	Moderate	Severe

Does your current condition cause:
__Depression __Anxiety __Stress

Would any of the following affect your compliance with Physical Therapy or an exercise program?
__Lack of Motivation __Anxiety
__Depression __Fear of Treatment
__Stress __Fear of Movement
__Memory problems
__Reading or Comprehension Issues
__Attention Deficit Disorder
__Time Restraint:____________________
__Other:____________________

HANDS ON
PHYSICAL THERAPY, PC

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