

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: _____ | ☐ unsure |
| ☐ No. of months: _____ | ☐ they come and go throughout the year |
| ☐ No. of years: _____ | ☐ No. of episodes/year: _____ |

How did your symptoms start? (please choose ONE answer that is most accurate)

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

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

Relative to the problem you are seeking care for today, 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 | ☐ 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 | ☐ fibromyalgia | ☐ muscular dystrophy (MD) |
| ☐ arthritis | ☐ GERD or reflux | ☐ obesity |
| ☐ asthma | ☐ gout | ☐ osteoarthritis |
| ☐ blood disorders | ☐ head injury | ☐ osteoporosis |
| ☐ broken bones/fractures | ☐ heart attack/MI | ☐ Parkinson disease |
| ☐ cancer | ☐ heart disease | ☐ peripheral neuropathy |
| ☐ COPD | ☐ hearing impairment | ☐ psychiatric disorders |
| ☐ deep vein thrombosis or pulmonary embolism | ☐ hypercholesteremia (high cholesterol) | ☐ repeated infections |
| ☐ depression | ☐ hypertension (high blood pressure) | ☐ seizures or epilepsy |
| ☐ developmental or growth problems | ☐ infectious disease (i.e. hepatitis) | ☐ spinal cord injury |
| ☐ diabetes Type 1 | ☐ kidney disease | ☐ skin diseases |
| ☐ diabetes Type 2 | ☐ liver disease | ☐ stomach problems or ulcers |
| ☐ eating disorder | ☐ low blood pressure | ☐ stroke |
| ☐ emphysema | ☐ multiple sclerosis (MS) | ☐ 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 | ☐ Cardiac catheterization | ☐ Joint Replacement: _____ |
| ☐ ACL repair/reconstruction | ☐ Cardiac surgery | ☐ Kidney Transplant |
| ☐ Achilles tendon repair | ☐ Carpal tunnel release | ☐ Liver Transplant |
| ☐ Angioplasty | ☐ Cholecystectomy (gallbladder removed) | ☐ Lung Surgery |
| ☐ Aortic Valve surgery | ☐ Chondroplasty | ☐ Lung Transplant |
| ☐ Appendectomy | ☐ Colon surgery | ☐ Lumpectomy |
| ☐ Arthroscopic Surgery: _____ | ☐ Colostomy | ☐ Mastectomy |
| ☐ Back surgery | ☐ Epidural injection | ☐ Neck surgery |
| ☐ Bariatric surgery | ☐ Femoral popliteal bypass | ☐ Pacemaker/Defibrillator |
| ☐ Bone marrow transplant | ☐ Hand surgery | ☐ Plastic surgery |
| ☐ Bunionectomy | ☐ Heart transplant | ☐ Rotator cuff repair |
| ☐ Coronary artery bypass graft | ☐ Hernia Repair | ☐ Splenectomy |
| ☐ Caesarian section | ☐ Hysterectomy | ☐ Tracheostomy |
| ☐ Prostate surgery | | |
| ☐ Other: _____ | | |

What diagnostic testing have you had?

- | | | |
|---|---|--|
| ☐ angiogram | ☐ EEG (electroencephalogram) | ☐ NCV (nerve conduction velocity) |
| ☐ blood work | ☐ EKG (electrocardiogram) | ☐ pap smear |
| ☐ bone scan | ☐ EMG (electromyogram) | ☐ pulmonary function test |
| ☐ CT scan | ☐ local steroid injection | ☐ spinal tap |
| ☐ colonoscopy | ☐ mammogram | ☐ stress test |
| ☐ doppler ultrasound | ☐ MRI | ☐ urine test |
| ☐ echocardiogram | ☐ myelogram | ☐ 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 many 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 | ☐ Student |
| ☐ Not employed/not seeking work | ☐ Unable to work due to injury |
| ☐ On disability unrelated to this problem | ☐ Unemployed, seeking work |
| ☐ On disability due to this problem | ☐ Working full duty, without restrictions |
| ☐ Retired | ☐ 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: