Name:_____**Date Completed: ___-___-___**

Emergency Contact Name: _____ Phone: (___)_____ Relationship:_____

RECENT/RELEVANT SURGERIES/PROCEDURES/IMAGING

Type of Procedures / Approximate Dates	Type of Procedures / Approximate Dates
1.	3.
2.	4.

MEDICATIONS

(List ALL of your Prescriptions/Over-The-Counter/Supplements OR attach a copy of your medication list)

Medication	Dosage/Freq	Condition	Medication	Dosage/Freq	Condition
1.			5.		
2.			6.		
3.			7.		
4.			8.		

MEDICAL HISTORY

(check any that may affect your ability to progress and/or improve function)

	Height_____ Weight_____ For Office Use Only: BMI:_____		Cancer Details:		Arthritis Details:
	Diabetes / Hypoglycemia		Anxiety/Depression		Gastrointestinal / Heartburn
	Hypertension / High Blood Pressure		Memory Loss/Difficulty Concentrating		Fatigue / Weakness/Fibromyalgia
	Incontinence		Hearing /Vision Difficulties		Chronic Obstructive Pulmonary Disorder COPD
	Congestive Heart Failure		Headaches		Asthma / Difficulty Breathing
	Peripheral Vascular Disease (PVD)		Vertigo / Dizziness / Fainting		Frequent Colds/Flus/Allergies
	Stroke		Back/Neck Pain		Degenerative Disc Disease (DDD)
	Myocardial Infarction (MI)/Heart Attack		Bruising / Scars / Skin-Tears / Wounds		Kidney Disease
	Angina		Skin is Sensitive to Hot / Cold packs		Parkinsons
	Edema / Swelling / Inflammation		Osteoporosis / Frequent Fractures		Neuropathy
	Cardiovascular Disease_____		Blood/Immune Disorder		Neurological Disease:_____
	Other:				

PERSONAL FACTORS

(check all statements that may affect your ability to progress and/or improve function)

	Hours slept/ night ____ Hours napped/day:____ Sleep interrupted ____x/night _____x/ day
	Hydration (glasses per day): Water _____ Coffee/Tea/Soda_____ Other:_____ _____
	I consider my diet is: □Poor □Moderate □Excellent ; I exercise _____min _____x/week
	My condition interrupts work ____x/week; other activities:_____x/week
	My condition impairs ability to finance housing, maintenance, nutrition, healthcare, other:__
	I am unable to drive to shop or attend medical appointments
	My condition interferes with driving, hygiene, housework, caring for family, attend appointments, socialize
	I could use more support at home for certain needs:_____
	I live with_____ My caregiver/support system is:_____
	I fell ____ times in last 12 months. I have been injured ____ times from falls
	I have difficulties doing things I did prior to my current condition. Describe task/action or activity: _____
	I am afraid of _____. I have difficulties communicating my needs, pain, disabilities, fears
	I am currently adjusting to new changes in my prescribed medications
	Other personal factors that may affect your ability to progress and/or improve function:

PRIMARY reason for coming to Physical Therapy:

CHECK boxes that correspond to your pain:

Check (ONE) for BEST Pain Level AND Check (ONE) for WORST Pain Level

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

0 1 2 3 4 5 6 7 8 9 10

No Pain **Worst pain possible**

Positions / Movements / Activities that CAUSE my PAIN (Check ALL that apply)

	Walking		Standing		Sitting		Twisting
	Sleeping		Turning in Bed		Sit-To-Stand		Reaching/Carrying
	Stooping/Squatting		Lying		Looking up/down/around		Driving

Please explain any other movements/positions/sports that cause pain:

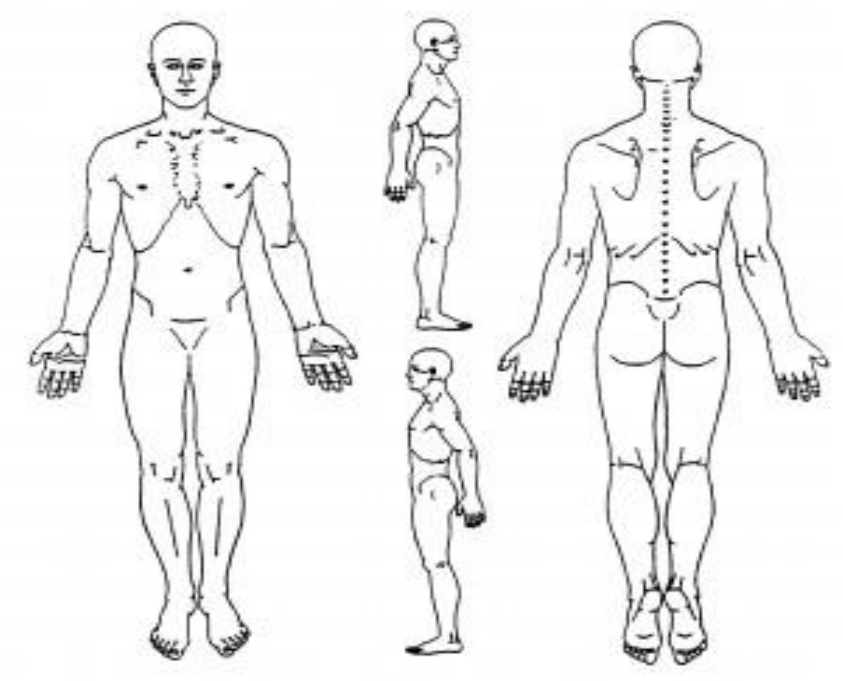
TYPE of PAIN (Check ALL that apply)

	Constant		Pulsing		Radiating		Aching
	Sporadic		Sharp		Burning		Tingling

Please explain any other types of pain:

PROGRESSION of PAIN (check YES or NO)

Is your pain getting worse?	□ YES □ NO
Has your pain spread into another area?	□ YES □ NO



"X" ALL OF THE AREAS YOU FEEL PAIN

Any other reasons for coming to Physical Therapy (if applicable):