C.H.O.O.S.E Physical Therapy

What is your major complaint today?	

Any special tests for this condition?	MRI CT Scan X-ray NVC/EMG Vestibular Other____________

Does this affect your ability to work?	Yes No	**Does this affect ability for household chores?**	Yes No

Does this affect your ability to take care of yourself?		**When did this start?**	**When did it get worse?**
Yes No	Explain:	Date:	Date:

What started this episode? And/or what made it worse?

Have you ever had a similar complaint before?	Yes No	**If so, when?** Date:

Did you receive treatment for previous complaint?	Yes No	Explain:

Have the symptoms changed in intensity, duration or location since this condition started? Explain:	Yes No

Have you received PT, OT or speech anywhere else this year for this condition or any other?	Yes No Dates:	**Have you had Home Health this year? (OT, PT, Speech, Aide, Wound care)** Dates____________ **Is someone coming to your home NOW?**	Yes No Yes No

Describe your pain: Please choose: Deep Superficial Other______ None	Constant Frequent Occasional

What makes your symptoms worse?	**What makes your symptoms better ?**

When it gets worse how long does it take to calm down?	Explain

On a scale of 0-10: Rate your pain **Now**: __/10	What is the **Worst** it has been in the last 3 days? __/10
What is the **Best** it has been in the last 3 days? __/10	What is the **Worst** since this started? __/10

Mark on the scale where your pain is **Now**?

0 1 2 3 4 5 6 7 8 9 10

Do you have any of the following symptoms? Please select all that apply:	
Numbness Tingling	Where?
Dizziness Lightheaded Balance problems Fall with injury Fall without injury	Explain:
Bowel issues Bladder issues	Explain:

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<table>
<tr><td>Pain with: Cough Sneeze Bowel Movement</td><td>Other:</td></tr>
<tr><td colspan="2">Difficulty with or history of any of the following: Speech Swallowing Nausea Double vision Passing out

Change in Walking pattern Nystagmus (uncontrolled repetitive eye movements) POTS

Explain:</td></tr>
<tr><td colspan="2">Living with: Family Spouse Alone Home health aide Roommate Family local Family distant No family

Dwelling: One story 2 story Condo Villa Apartment Assistive living facility

Entrance: Curbs Stairs Steps Elevator Walking Distance to door__________

Other/Explain:</td></tr>
<tr><td colspan="2">Occupation:</td></tr>
</table>

Form continues on following page

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Past and Present Medical History

Have you had injuries/pain in the following areas?

Click "Select" to answer "Yes/No." You must answer "Yes" or "No" for EVERY prompt.

Area	Body Area		Past or Present	
	Left	Right		
Headache			Present	Past
Migraine			Present	Past
Neck Pain			Present	Past
Shoulder			Present	Past
Elbow			Present	Past
Hands			Present	Past
Upper Back			Present	Past
Low Back			Present	Past
Pelvis			Present	Past
Hip			Present	Past
Knee			Present	Past
Ankle/ Foot			Present	Past
Concussion			Present	Past
Scoliosis			Changing	Stable

Medical Conditions	
High Blood Pressure	
Cardiac Condition	
Congestive heart failure	
Seizures Epilepsy	
Stroke	
Pacemaker	
Heart Condition	
Chronic Pain	
Chronic fatigue	
Parkinsons	
Lupus	
Rheumatoid arthritis	
Osteoarthritis	
Recent Infection	

Medical Conditions	
Bleeding Disorder	
EDS or Hypermobility	
COPD/Asthma	
Emphysema	
Osteoporosis Osteopenia	
Multiple Sclerosis	
Chronic Covid Long Haul	
Dysautonomia POTS	
Lymes /Epstein Barre	
Peripheral Neuropathy	
Fibromyalgia	
Cancer	
Radiation Chemo Surgery	
Pregnant? # of wks. ____	

Do you Have Allergies? Please select: Tape Chocolate Insects Nuts Latex Environmental Other ____________ None

Please List Surgeries: (or provide a list):____

____

____

Please list current medications (or provide a list)____

____

____

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Other medical conditions or precautions not listed:____

____

Please identify up to 3-5 important activities that you are unable to do or are having difficulty with because of your current problem/injury. Please list below and rate the difficulty from 0-10 and fill in tolerance prior to activity and now.

Patient-specific activity scoring scheme: Rating from 0-10

0 (unable to perform activity) 1 2 3 4 5 6 7 8 9 10 (Able to perform at the previous level)

List an Activity	**Date:**	**Time and/or Distance**	**Time and/or Distance**
	Rate 0/10-10/10	**Prior to current issue**	**Now**
Example 1: Sitting	5/10	(No limitations (10/10))	30 minutes
Example 2: Walking	2/10	1 hour or > 1 mile	10 minutes or 2 blocks
1.			
2.			
3.			
4.			
5.			

Please check all of the following below that either increase your pain or are difficult to do independently.

- □ Eating
- □ Cooking
- □ Getting into/out of…
  - □ Tub/shower
  - □ Chair
  - □ Bed
  - □ Toilet
  - □ Car
- □ Washing/drying…
  - □ Hair
  - □ Body
  - □ Face
- □ Applying makeup
- □ Shaving
- □ Dressing/undressing
- □ Putting on/off
  - □ Shoes/socks
  - □ Clothing
- □ Brushing…
  - □ Hair
  - □ Teeth
- □ Opening/Closing…
  - □ Car Door
  - □ Heavy Door
  - □ Sliding Door
- □ Walking…
  - □ From room to room
  - □ Upstairs
  - □ Downstairs
  - □ Up an incline
  - □ Down an incline
  - □ Up a curb
  - □ Down a curb
  - □ on soft surfaces
  - □ on hard surfaces
  - □ on uneven surfaces
- □ Balance issues…
  - □ From room to room
  - □ On soft surfaces
  - □ On hard surfaces
  - □ on uneven surfaces
- □ Food shopping
- □ Standing
- □ Sitting
- □ Carrying…
  - □ Groceries
  - □ Purse
- □ Sitting
  - □ Backing up vehicle
  - □ Driving
- □ Kneeling/get up from kneeling
- □ Squatting/get up from squatting
- □ Getting down/up from floor
- □ Putting…
  - □ Wallet in pocket
  - □ On seatbelt
- □ Getting items from…
  - □ High places
  - □ Low places
- □ Sweeping
- □ Vacuuming
- □ Ironing
- □ Making the bed
- □ Reaching
- □ Washing laundry
- □ Folding laundry

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BODY CHART

Please **Color and Draw** on the body outline to show where your symptoms are:

RIGHT SIDE BACK FRONT LEFT SIDE

LEFT RIGHT RIGHT LEFT

Name: ____ Date: ____________________

Use a **Pen and /or Markers** to document the following as appropriate

Numbness: XXXXXX

Tingling: ////////

Sharp Shooting Pain:

Ache: 0000000

Burning: +++++++

Other: __________*****

Severe Pain: Pink

Moderate Pain: Blue

Minimal Pain: Green

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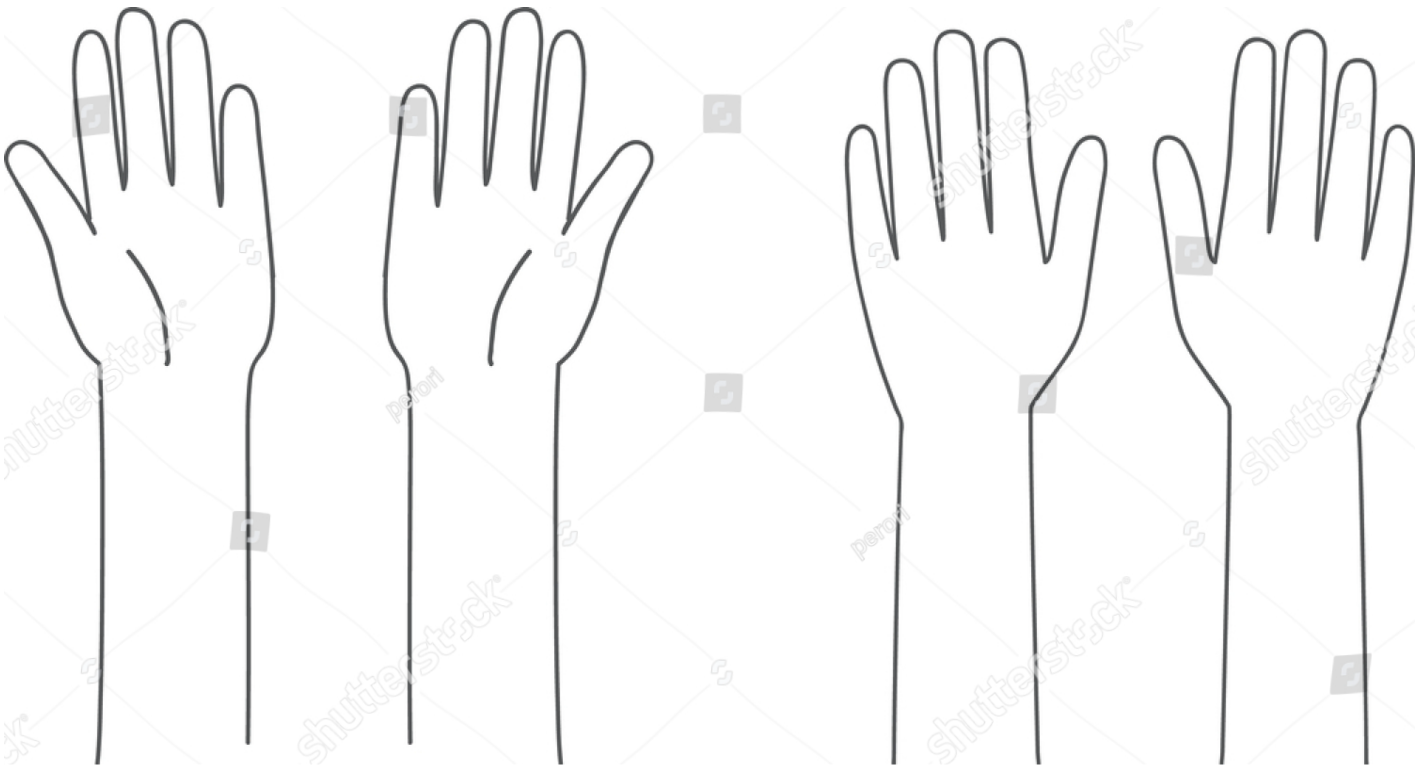

Name: ____ Date: ________________________

Use a **Pen and /or Markers** to document the following as appropriate.

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Sharp Shooting Pain: ↓↓ ↓

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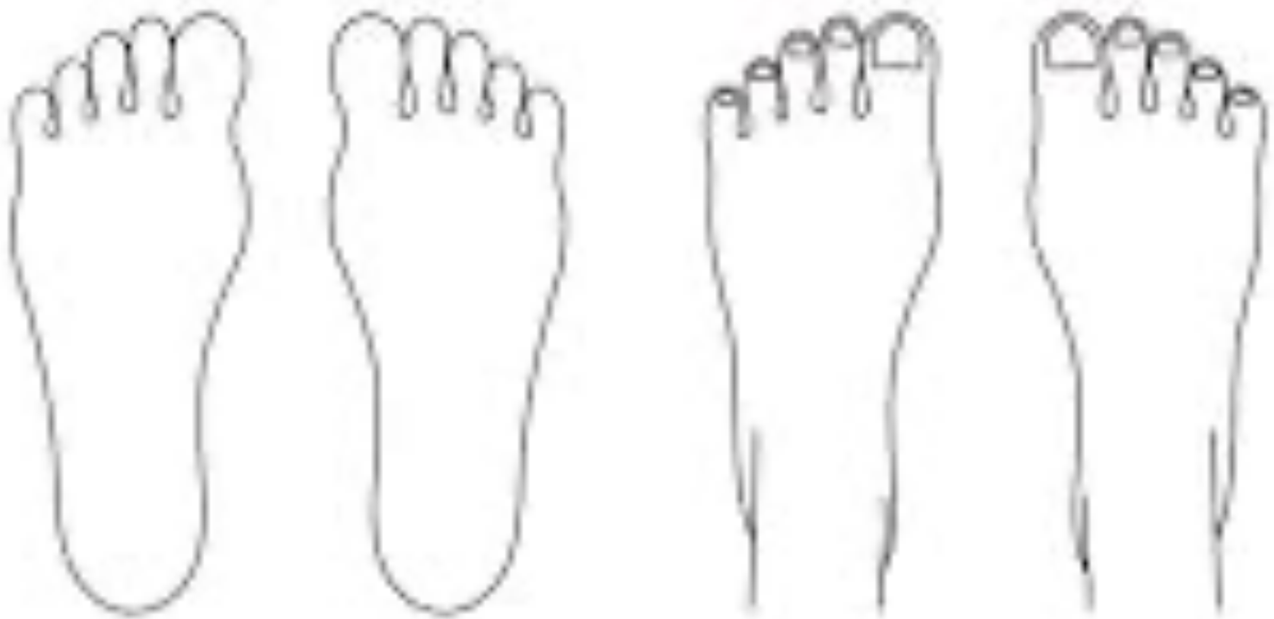

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