

Date: _____ Patient Name: _____

Patient Account #: _____

13. Please check /list any other health care providers you are currently seeing for this condition: None

- MD _____ Dentist
- Podiatrist Chiropractor
- Physical therapist

14. Please check if you have you had any of the following?

- none EMG x-rays
- CT scan / MRI other _____

GENERAL HEALTH

Age: _____ Height: _____ Weight: _____

Dominant hand (circle): **R** **L**

How would you rate your overall health?

- Excellent Good Average Fair Poor

Are you pregnant No Yes date due: ___/___/___

Apart from your daily activities do you exercise?

- 5+ days/wk 3-4 days/wk 1-2 days/wk
- occasionally zero

Do you drink caffeinated beverages? No Yes _____/day

Do you smoke? No Yes _____ packs/day

What is your stress level?

- Low Medium High

MEDICATION

Please list any prescription and/or over the counter medications you are currently taking (pain pills, injections, skin patches, aspirin, multi vitamins, etc) see attached list

_____	_____
_____	_____
_____	_____

PAST/CURRENT MEDICAL HISTORY

Have you ever had/been diagnosed with any of the following conditions? (check all that apply) None

- | | |
|--|--|
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Chemical dependency |
| <input type="checkbox"/> Heart problems | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> HIV | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Lung problems/asthma |
| <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Incontinence |
| <input type="checkbox"/> Thyroid | <input type="checkbox"/> Blood disorder/anemia |
| <input type="checkbox"/> Epilepsy/seizures/dizziness | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Arthritis-OA/RA, osteopenia/osteoporosis | <input type="checkbox"/> Fractures |
| <input type="checkbox"/> Head injury | <input type="checkbox"/> Stomach problems |
| <input type="checkbox"/> Circular/vascular problems | <input type="checkbox"/> Parkinson's |
| <input type="checkbox"/> Infectious disease (i.e. hepatitis, tuberculosis, etc.) | |
| <input type="checkbox"/> Spine problems / surgery <input type="checkbox"/> Other _____ | |
| <input type="checkbox"/> List any other surgeries _____ | |

FAMILY HISTORY

Has anyone in your immediate family (parents, brothers, sisters) ever been diagnosed with any of the following?

- Diabetes Stroke Cancer _____
- Heart disease Arthritis OA/RA
- High blood pressure Psychological condition
- other _____

LIVING SITUATION

- live alone live with family members/others/caregiver
- home / apartment / retirement complex (independent/assisted)
- driving other _____

Environment

- stairs (railing) no stairs
- stairs (no railing) elevator
- other _____

PREVIOUS FUNCTIONAL LEVEL

- Independent in all activities (work, home, recreation, community)

Self Care

- Independent (bathing, toileting, dressing, etc.)
- Difficulty performing self care activities
- Need assistance with self care activities
- Difficulty performing household chores

Social/Recreational/Leisure

- Limited in _____

What are your goals for therapy? _____

WORK HISTORY

Occupation

- full time self student
- part time retired unemployed
- other _____

Physical activities at work

- sitting standing computer use
- phone use repetitive lifting driving
- heavy equipment operation heavy lifting

Current working status full duty restricted duty

Work days missed _____

If not performing your normal activities at work do you plan to return to your previous activity level? Yes No

If this is a Work Comp claim - Do you have a QRC? Yes No

Are you seeking disability or are you consulting an attorney for this condition? Yes No

Patient / guardian signature: _____

M.D. follow up _____/_____/_____

Reviewed by therapist: _____

Date: _____/_____/_____