



1. Name:

Last
First MI Jr/Sr

2. Are you: a Right-handed b Left-handed

3. Type of Insurance: a Insurer b Workers' Comp c Medicare d Self-pay e Other

4. Race: a Asian b Native Hawaiian/ Pacific Islander c Black d White
5. Ethnicity: a Hispanic or Latino b Not Hispanic or Latino
6. Language: a English understood? b Interpreter needed? c Language you speak most often:

7. Education: a Highest grade completed (Circle one): 1 2 3 4 5 6 7 8 9 10 11 12 b Some college / technical school c College graduate d Graduate school / advanced degree

SOCIAL HISTORY

8. Cultural/Religious: Any customs or religious beliefs or wishes that might affect care?

9. With whom do you live:

- a Alone
b Spouse only
c Spouse and other(s)
d Child (not spouse)
e Other relative(s) (not spouse or children)
f Group setting
g Personal care attendant
h Other:

10. Who referred you to the physical therapist?

11. Employment/Work (Job/School/Play)

- a Working full-time outside of home
b Working part-time outside of home
c Working full-time from home
d Working part-time from home
e Homemaker f Student g Retired h Unemployed
i Occupation:

LIVING ENVIRONMENT

12. Does your home have:

- a Stairs, no railing
b Stairs, railing
c Ramps
d Elevator
e Uneven terrain
f Assistive devices (eg bathroom)
g Any obstacles:

13. Do you use:

- a Cane
b Walker or rollator
c Manual Wheelchair
d Motorized wheelchair
e Glasses, hearing aids
f Other:

14. Where do you live:

- a Private home
b Private apartment
c Rented room
d Board and care / assisted living / group home
e Homeless (with or without shelter)
f Long-term care facility (nursing home)
g Hospice
h Other:

15. GENERAL HEALTH STATUS

a Please rate your health:

- (1) Excellent (2) Good (3) Fair (4) Poor
b Have you had any major life changes during past year? (eg, new baby, job change, death of a family member) (1) Yes (2) No

16. SOCIAL/HEALTH HABITS

a Smoking

- (1) Currently smoke tobacco (a) Yes 1. Cigarettes: # of packs per day (b) No

(2) Smoked in past? (a) Yes Year quit: (b) No

b Alcohol

(1) How many days per week do you drink beer, wine, or other alcoholic beverages, on average?

(2) If one beer, one glass of wine, or one cocktail equals one drink, how many drinks do you have on an average day?

c Exercise

Do you exercise beyond normal daily activities and chores?

- (a) Yes Describe the exercise: 1. On average, how many days per week do you exercise or do physical activity? 2. For how many minutes, on an average day? (b) No

17. FAMILY HISTORY (Indicate whether mother, father, brother/sister, aunt/uncle, or grandmother/grandfather, and age of onset if known)

- a Heart disease:
b Hypertension:
c Stroke:
d Diabetes:
e Cancer:
f Psychological:
g Arthritis:
h Osteoporosis:
i Other:

18. MEDICAL/SURGICAL HISTORY

a Please check if you have ever had:

- (1) Arthritis (13) Depression
(2) Broken bone/Fractures (14) Muscular dystrophy
(3) Osteoporosis (15) Parkinson disease
(4) Blood disorders (16) Seizures/epilepsy
(5) Circulation/vascular Problems (17) Allergies
(6) Heart problems (18) Developmental or growth Problems
(7) High Blood Pressure (19) Thyroid problems
(8) Lung problems (20) Cancer
(9) Stroke (21) Infectious disease
(10) Diabetes/ high blood sugar (eg, tuberculosis, hepatitis)
(11) Low blood sugar/ Hypoglycemia (22) Kidney problems
(12) Head injury (23) Repeated infections
(13) Multiple sclerosis (24) Ulcers/stomach problems
(25) Skin diseases
(27) Other:

b Within the past year, have you had any of the following symptoms? (Check all that apply)

- (1) Chest pain (13) Difficulty sleeping
(2) Heart palpitations (14) Loss of appetite
(3) Cough (15) Nausea/vomiting
(4) Hoarseness (16) Difficulty swallowing
(5) Shortness of breath (17) Bowel problems
(6) Dizziness or blackouts (18) Weight loss/gain
(7) Coordination problems (19) Urinary problems
(8) Weakness in arms or legs (20) Fever/chills/sweats
(9) Loss of balance (21) Headaches
(10) Difficulty walking (22) Hearing problems
(11) Joint pain or swelling (23) Vision problems
(12) Pain at night (24) Other:

c Have you ever had surgery? (1) Yes (2) No

If yes, please describe, and include dates:

Month Year
00 0000
00 0000
00 0000

For men only: d Have you been diagnosed with prostate disease?

(1) Yes (2) No

For women only:

Have you been diagnosed with:

h Complicated pregnancies or deliveries?

e Pelvic inflammatory disease?

(1) Yes (2) No

i Pregnant, or think you might be pregnant?

f Endometriosis?

(1) Yes (2) No

(1) Yes (2) No

j Other gynecological or obstetrical difficulties?

g Trouble with your period?

(1) Yes (2) No

(1) Yes (2) No

If yes, please describe:

19. CURRENT CONDITION(S)/CHIEF COMPLAINT(S)

a Describe the problem(s) for which you seek physical therapy:

Month Year

b When did the problem(s) begin (date)? 00 0000

c What happened?

d Have you ever had the problem(s) before?

(1) Yes (2) No

(a) What did you do for the problem(s)?

(b) Did the problem(s) get better?

1. Yes 2. No

(c) About how long did the problem(s) last?

20. Current Condition(s)/Chief Complaint(s) (continued)

e How are you taking care of the problem(s) now?

f What makes the problem(s) better?

g What makes the problem(s) worse?

h What are your goals for physical therapy?

i Are you seeing anyone else for the problem(s)? (Check all that apply)

- (1) Acupuncturist (10) Occupational therapist
(2) Cardiologist (11) Orthopedist
(3) Chiropractor (12) Osteopath
(4) Dentist (13) Pediatrician
(5) Family practitioner (14) Podiatrist
(6) Internist (15) Primary care physician
(7) Massage therapist (16) Rheumatologist
(8) Neurologist
(9) Obstetrician/gynecologist
Other

21. FUNCTIONAL STATUS/ACTIVITY LEVEL (Check all that apply)

a Difficulty with locomotion/movement:

- (1) Bed mobility
(2) Transfers (such as moving from bed to chair, from bed to commode)
(3) Gait (walking)
(a) On level (c) On ramps
(b) On stairs (d) On uneven terrain

b Difficulty with self-care (such as bathing, dressing, eating, toileting)

c Difficulty with home management (such as household chores, shopping, driving/transportation, care of dependents)

d Difficulty with community and work activities/integration

- (1) Work/school
(2) Recreation or play activity

22. MEDICATIONS

a Do you take any prescription medications? (1) Yes (2) No

If yes, please list:

b Do you take any nonprescription medications?

(Check all that apply)

- (1) Advil/Aleve (6) Decongestants
(2) Antacids (7) Herbal supplements
(3) Ibuprofen/ Naproxen (8) Tylenol
(4) Antihistamines (9) Other:
(5) Aspirin

c Have you taken any medications previously for the

condition for which you are seeing the physical therapist?

(1) Yes (2) No If yes, please list:

23. OTHER CLINICAL TESTS Within the past year, have you had any

of the following tests? (Check all that apply)

- a Angiogram m Mammogram
b Arthroscopy n MRI
c Biopsy o Myelogram
d Blood tests p NCV (nerve conduction velocity)
e Bone scan q Pap smear
f Bronchoscopy r Pulmonary function test
g CT scan s Spinal Tap
h Doppler ultrasound t Stool tests
i Echocardiogram u Stress test (eg, treadmill, bicycle)
j EEG (electroencephalogram) v Urine tests
k EKG (electrocardiogram) x X-rays
l EMG (electromyogram) y Other: