Physical Therapy Screening/Confidential Medical History

Name: ______________________________ **Date:** ___/___/___ **Age:** _____ **Birth date:** ___/___/_____

Please complete the following questions to the best of your ability. This will help us to develop a treatment plan that meets your individual needs. **Circle or 'X' listed responses that apply.**

What is your major complaint? ______________________________

Date of injury or onset of problem: ____________________ How did your current problem begin? ___ lifting ___ twisting ____ falling ____repetitive motion ____ motor vehicle accident ____ sports ____ gradually ____ unknown ___ other: ______________________________

This condition is ____improving ____worsening ____static. Aggravating factors: ___ sitting ___standing ___changing positions ___lifting ___ reaching ____turning ____dressing ____sleeping ____work ___other: ____________________

Date of last complete physical exam: __________ Primary Doctor: ____________________

Has your Doctor given you any restrictions? ______________________________

Tests performed? ___ X-Ray ___MRI ___CT Scan ___ Ultrasound ___ Other: ____________________

List surgical operations (including dental) **past to recent**: ______________________________

____

Please indicate medications that you are taking: ___ anticoagulation (e.g. coumadin) ___ steroidal medications (e.g. Prednisone) ___ allergy meds ____ Pain meds ___ anti-inflammatory ___ Cholesterol meds ___ hypertension meds ___ cardiac meds ___chemotherapy(last dose______) ____non-prescription meds ___ other. **List Medications & Supplements:** ______________________________

____

Do you have or have you had any of the following disease process or conditions? Circle or check

Osteoarthritis	Heart disease	↑ blood pressure/cholesterol	Pregnancy (now? Y/N)	Pelvic pain/issues
Rheumatoid Arthritis	Diabetes	Congestive heart failure	Spine/bone (pain/condition)	Skin condition
Osteoporosis	Stroke	Pacemaker/arrhythmia	Drug/alcohol dependency	Depression/anxiety
Fibromyalgia	Seizures	Cancer (type:)	Respiratory condition	Allergies
Thyroid problems	Multiple sclerosis	Kidney disease/problem	Asthma (peak flow:)	Blood vessel problem
Stomach ulcer	Abdominal pain/issue	Urinary/bladder problem	Lung disease (TB, other)	Blood disorder
GI problems	Hernia	Prostate issue	Sleep issue/apnea/insomnia	Hepatitis (A,B,C?)
Falls(# in past yr)	Headache problems	Weight or Appetite change	Hormone issues/menopause	Fatigue

Specify above & if others please list: ______________________________

Parent/sibling history of above (list): ______________________________

Have you been hospitalized in the past year? Specify: ____________________ NO Yes

In the past several months, have you experienced:

- Difficulty falling asleep or returning to sleep because of the pain or pain that wakes you up? NO Yes
- Fever, chills or night sweats? . . . . NO Yes
- Shortness of breath or chest pain? . . . . NO Yes
- Bowel or bladder irregularities? Specify ____________________ NO Yes
- Pain and difficulty with jaw movement? . . . . NO Yes
- Pulsating headache? . . . . NO Yes
- Nausea or vomiting? . . . . NO Yes
- Fainting or blackout episode? . . . . NO Yes
- Dizziness or lightheadedness aggravated by neck motion? . . . . NO Yes
- Double vision or blurred vision? . . . . NO Yes
- Pain, tingling, or numbness in and around your face? . . . . NO Yes
- Ringing in the ears? . . . . NO Yes
- Difficulty swallowing or speaking? . . . . NO Yes
- Problems with balance when you walk? . . . . NO Yes
- Tingling or numbness in both of your arms, hands, or legs? . . . . NO Yes
- Recent illness or infection? (fever, chills, night sweats, rash, __________) . . . . . . NO Yes

Does your entire affected limb(s), hand(s) or feet feel numb? NO Yes

Do your symptoms improve with movement? NO Yes

Do you smoke? If so, number of packs/day: ____________________ NO Yes
Do you drink alcoholic beverages? If so, drinks per week: ____________________ NO Yes
Do you have any allergies (food/medication/airborne)? ____________________ NO Yes
Do you have chemical, latex/rubber or tape/adhesive sensitivity? ____________________ NO Yes
Are you presently working? ___Regular or ___Light/modified duty? ___Part time ___Retired NO Yes
Occupation/tasks/exposures: ____________________
Have you had a significant past trauma (motor vehicle accident, blow or injury to the neck or head)? NO Yes
Specify: ____________________
Have you had Physical, Occupational or Speech Therapy any time this past year? NO Yes

Are you ____right or ____left handed? Are you ambidextrous? ______
Are you **currently** being seen by any of the following? ___chiropractor ___osteopath ____physical therapist ___speech therapist ____occupational therapist ____psychiatrist/psychologist. Reason: ____________________

Do you use an assistive device? __NO __cane __walker __wheelchair __orthotics __brace __splint, Other____________
What type of exercise are you currently doing? ____________________
When injury free? ____________________ Goal(s)? ____________________
What are your hobbies or recreational activities? ____________________
Rate your **general stress level** on a scale from none to extreme: **0 1 2 3 4 5 6 7 8 9 10**
Other complaints or health issues: ____________________
How long has it been since you really felt good? ____________________

Prior Level of Function: (Mark all that apply)

____Prior to the onset of my problem I was independent in my activities of daily living (ADLs) and recreational activities without pain or difficulty.
____I was independent in my ADLs with some pain and a little difficulty.
____I was able to work at ___full ___partial capacity __with ___without pain or difficulty.
____I needed assistance or had difficulty performing: ____________________
____I was limited due to ___pain ___weakness ___ endurance ___ fatigue ___other: ____________________

Current Level of Function: (Mark all that apply)

____I am currently independent in my activities of daily living and recreational activities without pain or difficulty.
____I am independent in my ADLs with some pain and a little difficulty.
____I am able to work at ___full ___partial capacity ___with ___without pain or difficulty.
____I need assistance or have difficulty performing: ____________________
____I am limited due to ___pain ___weakness ___ endurance ___ fatigue ___other: ____________________

I attest to the accuracy of the information I provided above:

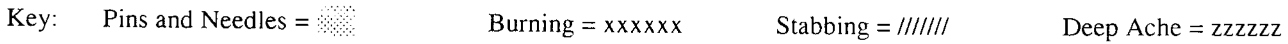
____________________ ____________________
Patient Signature **Date**

Therapist use only: ☐ *I have reviewed this information together with the patient.* Treatment Precautions: Vital Signs: **BP** / **PR** b/min **RR** /min	**Date of Onset/exacerbation:**
BMI: Ht. **inches** **Wt.** **pounds**	
Therapist Signature: Date:	

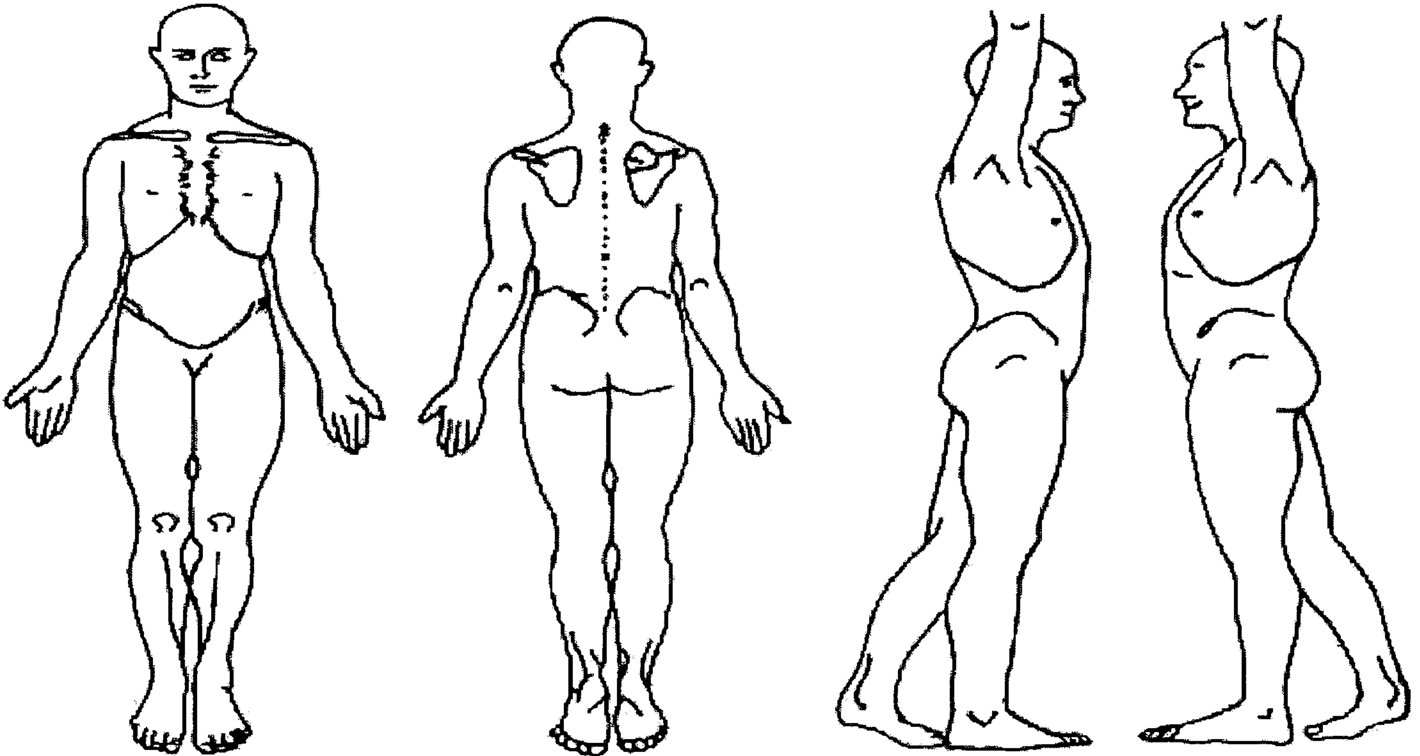
Body Chart

NAME: ______________________________ **Date:** ____/____/____ **Birth date:** ____/____/____

Please use the diagram below to indicate the symptoms you have experienced over the past 24 hours. **Be VERY precise when drawing the location of your pain.** **Use the key to indicate the type of symptoms.**



Key: Pins and Needles = ░ Burning = xxxxxx Stabbing = /////// Deep Ache = zzzzzz



Rate your pain using the following scale, with 0 being no pain and 10 being very severe pain.

During rest: **0 1 2 3 4 5 6 7 8 9 10**

During activity: **0 1 2 3 4 5 6 7 8 9 10**

How would you describe your overall health? ____excellent ____very good ____good ____fair ____poor

Current living situation: ___live alone ___live with spouse/family ___live in assisted living ___other: ____________

Does your home/apartment have stairs? ___yes ___no Railings? ___yes ___no

What are your goals for therapy? ____