Freedom Physical Therapy & Sports Rehabilitation

Patient initials: _____

Today's Date: _____

Name:_____

Address:_____

City:_____State:_____Zip:_____

Best contact phone #: 1:_____ 2:_____

Email:_____

Emergency contact name:_____

Emergency contact phone #:_____

Date of Birth:_____ Age: _____

Employer name:_____

Employer phone #:_____

Sex: ☐ Male ☐ Female **Marital status:** ☐ Married ☐ Single ☐ Widowed

Are you: ☐ Right-handed ☐ Left-handed

Who referred you to Freedom Physical Therapy?

_____

SOCIAL HISTORY

With whom do you live:

☐ Alone
☐ Spouse only
☐ Spouse and other(s)
☐ Child (not spouse)
☐ Other relative(s) (not spouse or children)
☐ Group setting
☐ Personal care attendant
☐ Other: _____

Where do you live:

☐ Private home
☐ Private apartment
☐ Assisted living/group home
☐ Rented room
☐ Other: _____

Employment/Work (Job/School/Play)

☐ Working full-time ☐ Working part-time ☐ Unemployed
☐ Homemaker ☐ Student ☐ Retired

Occupation: _____

LIVING ENVIRONMENT

Does your home have:

☐ Stairs, without railing ☐ Stairs, with railing ☐ Ramps
☐ Elevator ☐ Uneven terrain ☐ Toilet riser
☐ Bath bench ☐ Other: _____

Do you use:

☐ Cane
☐ Walker without wheels
☐ Front-wheel walker
☐ 4 wheel walker
☐ Manual wheelchair
☐ Motorized wheelchair
☐ Glasses, hearing aids
☐ Quad cane
☐ Other: _____

SOCIAL/HEALTH HABITS

Smoking

Currently smoke tobacco? ☐ Yes ☐ No

☐ Cigarettes:
# of packs per day _____

☐ Cigars/Pipes:
per day _____

Smoked in past? ☐ Yes Year quit: _____ ☐ No

Alcohol

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

How many drinks do you have, on an average day? _____

Exercise

Do you exercise beyond normal daily activities and chores? ☐ Yes ☐ No

☐ If yes, describe the exercise: _____

On average, how many days per week do you exercise or do physical activity? _____ For how many minutes on an average day? _____

MEDICAL/SURGICAL HISTORY

Please check if you have **EVER** been diagnosed with any of the following:

☐ Rheumatoid arthritis
☐ Broken bones/fractures
☐ Other arthritic condition
☐ Bladder/urinary tract infection
☐ Osteoporosis
☐ Blood disorders
☐ Kidney problem/infection
☐ Pneumonia
☐ Circulation/vascular problems
☐ Heart problems
☐ High blood pressure
☐ Lung problems
☐ Stroke
☐ Diabetes/high blood sugar
☐ Low blood sugar/hypoglycemia
☐ Head injury
☐ Multiple sclerosis
☐ Muscular dystrophy
☐ Parkinson disease
☐ Seizures/epilepsy
☐ Allergies
☐ Depression
☐ Thyroid problems
☐ Cancer
☐ Kidney problems
☐ Repeated infections
☐ Ulcers/stomach problems
☐ Skin diseases
☐ Developmental or growth problems
☐ Anemia
☐ Bone or joint infection
☐ Asthma/bronchitis
☐ Chemical dependency (i.e., drugs, alcohol)
☐ Liver problems (e.g., hepatitis)
☐ Infectious disease (e.g., tuberculosis)
☐ Pelvic inflammatory disease
☐ Sexually transmitted disease/HIV
☐ Clots in deep veins
☐ Other: _____

Please check if you have **RECENTLY** had any of the following symptoms:

☐ Fatigue
☐ Difficulty walking
☐ Fever/chills/sweats
☐ Loss of consciousness/fainting
☐ Nausea/vomiting
☐ Dizziness or blackouts
☐ Weight loss/gain
☐ Blood in saliva/phlegm
☐ Balance problems/falls
☐ Coordination problems
☐ Dizziness/light-headed
☐ Pain at night
☐ Chest and/or shoulder pain
☐ Heart palpitations
☐ Persistent cough
☐ Hoarseness
☐ Shortness of breath
☐ Weakness in arms or legs
☐ Numbness in "saddle" area
☐ Non-healing sore/wound
☐ Joint pain or swelling
☐ Blood in urine/bowel movement
☐ Difficulty sleeping
☐ Loss or increase in appetite
☐ Numbness/tingling
☐ Difficulty swallowing
☐ Constipation/diarrhea
☐ Heartburn/indigestion
☐ Swelling in legs
☐ Bowel function (pain/color/shape/function)
☐ Wheezing
☐ Urinary problems (pain/color/function)
☐ Headaches
☐ Hearing problems
☐ Vision problems
☐ Throbbing/pulsating sensation in abdomen
☐ Morning stiffness >30 min
☐ Pain worse with rest & better with activity
☐ Increased thirst or urination
☐ Other: _____

Have you ever had surgery? ☐ Yes ☐ No

If yes, please describe, and include dates:

	Month	Year
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

For women only:

Have you been diagnosed with:

Pelvic inflammatory disease? ☐ Yes ☐ No
Endometriosis? ☐ Yes ☐ No
Trouble with your period? ☐ Yes ☐ No
Complicated pregnancies or deliveries? ☐ Yes ☐ No
Pregnant, or think you might be pregnant? ☐ Yes ☐ No
Other gynecological or obstetrical difficulties? ☐ Yes ☐ No
If yes, please describe: _____

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For men only:
Have you been diagnosed with prostate disease? ☐ Yes ☐ No

Patient initials: _____

FAMILY HISTORY

Please check if **anyone** in your **immediate family** (parents, brothers, sisters) has EVER been diagnosed with any of the following:

☐ Heart disease
☐ Stroke
☐ Cancer
☐ Arthritis
☐ Other _____
☐ Hypertension
☐ Diabetes
☐ Psychological
☐ Osteoporosis

GENERAL HEALTH STATUS

Please rate your health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Have you had any major life changes during past year? (e.g., new baby, job change, death of a family member) ☐ Yes ☐ No

What is your current stress level? ☐ Low ☐ Moderate ☐ High

How are you currently sleeping? ☐ Fine ☐ Moderate problems ☐ Poor

How often do you awaken due to pain? _____ Due to other reasons? _____

During the past month have you been feeling down, depressed or hopeless?
☐ Yes ☐ No

During the past month have you been bothered by having little interest or pleasure in doing things?
☐ Yes ☐ No

Is feeling down, depressed or hopeless something which you would like help?
☐ Yes ☐ Yes, But Not Today ☐ No

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

☐ Acupuncturist
☐ Chiropractor
☐ Family practitioner
☐ Massage therapist
☐ Occupational therapist
☐ Podiatrist
☐ Rheumatologist
☐ Cardiologist
☐ Dentist
☐ Internist
☐ Neurologist
☐ Orthopedist
☐ Primary care physician
☐ Other:_____

OTHER CLINICAL TESTS—Within the past year, have you had any of the following tests? (Check all that apply)

☐ Angiogram
☐ Arthroscopy
☐ Biopsy
☐ Blood tests
☐ Bone scan
☐ Bronchoscopy
☐ CT scan
☐ Doppler ultrasound
☐ Echocardiogram
☐ EEG (electroencephalogram)
☐ EKG (electrocardiogram)
☐ EMG (electromyogram)
☐ Mammogram
☐ MRI
☐ Myelogram
☐ NCV (nerve conduction)
☐ Pap smear
☐ Pulmonary function test
☐ Spinal tap
☐ Stool tests
☐ Stress test (eg, treadmill/ bicycle)
☐ Urine tests
☐ X-rays
☐ Other:_____

MEDICATIONS

Do you take any prescription medications? ☐ Yes ☐ No
If yes, please list: _____

Do you take any nonprescription medications? (Check all that apply)

☐ Advil/Aleve
☐ Ibuprofen/Naproxen
☐ Aspirin
☐ Herbal supplements
☐ Antacids
☐ Antihistamines
☐ Decongestants
☐ Tylenol
☐ Other:_____

Have you taken steroid medications for any medical condition?
☐ Yes ☐ No

Do you take blood thinners (anticoagulants) or anti-inflammatories for any medical condition? ☐ Yes ☐ No

CURRENT CONDITION(S)/CHIEF COMPLAINT(S)

Current Functional Status/Activity Level (Check all that apply):

Difficulty with moving: ☐ Arm(s) ☐ Leg(s) ☐ Neck ☐ Trunk

Difficulty with moving: ☐ Within bed ☐ In/out of bed ☐ From sit to stand ☐ From standing to sitting (i.e., to chair or toilet)

Difficulty with walking: ☐ on level ☐ on ramps ☐ on stairs ☐ on uneven terrain

Difficulty with self-care: ☐ bathing ☐ dressing ☐ eating ☐ toileting

Difficulty with home management: ☐ Household chores ☐ Shopping ☐ Driving/transportation ☐ Care of dependents

Difficulty with: ☐ Shopping ☐ Community and work activities ☐ Work/school ☐ Recreation or play activity

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

_____
_____
_____
_____

When did the problem(s) begin (date)? _____

What happened? _____

Have you ever had the problem(s) before? ☐ Yes ☐ No
If yes, what did you do for the problem(s)? _____
Did the problem(s) get better? ☐ Yes ☐ No
How long did the problem(s) last? _____

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

What makes the problem(s) better? _____

What makes the problem(s) worse? ☐ Lying down ☐ Standing ☐ Sitting ☐ Walking ☐ Stress ☐ Bending forward ☐ Bending back ☐ Stairs ☐ Squatting ☐ Other:_____

What are your goals for physical therapy? _____

Physical Therapist Notes

Freedom Physical Therapy & Sports Rehabilitation

Today's Date: _____ Patient initials: _____

Identify up to 3 important activities you are <u>unable to do</u> or are <u>having difficulty with</u> as a result of your problem:

1. _____ Rating #1: _____
2. _____ Rating #2: _____
3. _____ Rating #3: _____

0 1 2 3 4 5 6 7 8 9 10 Average: _____

Unable to perform activity — Able to perform activity at same level as before injury or problem

Consent for treatment: I understand that my diagnosis and treatment plan will be discussed during my appointment and that I have the right to question and/or refuse any treatment offered.

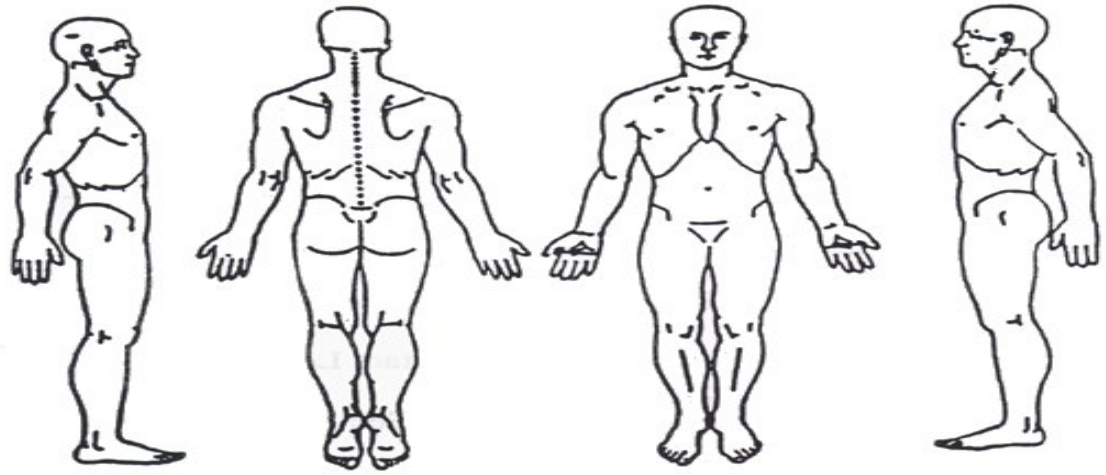
Signed: _____

Body Chart

Please mark the areas where you feel symptoms on the body chart below. Use the legend to describe your symptoms:

Legend:

- ↓ Shooting/sharp pain
- O Dull/aching pain
- /// Sharp pain
- X Numbness
- ++ Tingling



Pain Scale

Between 0 and 10 where **<u>0 is no pain</u>** and **<u>10 is the worse pain imaginable</u>** please rate your pain below.

No Pain: 1 2 3 4 5 6 7 8 9 10 **Worse Pain Imaginable**

Physical Therapist Only: Do not fill out boxes below

PROBLEM 1:
<u>Onset:</u>
Constant Intermittent Variable
<u>Pain Range (24 hrs):</u>
Best: Current: Worst:

<u>Quality:</u>
<u>Aggr:</u>
<u>Ease:</u>
<u>24 hour:</u>
<u>Irritability:</u>

PROBLEM 2:
<u>Onset:</u>
Constant Intermittent Variable
<u>Pain Range (24 hrs):</u>
Best: Current: Worst:

<u>Quality:</u>
<u>Aggr:</u>
<u>Ease:</u>
<u>24 hour:</u>
<u>Irritability:</u>

PROBLEM 3:
<u>Onset:</u>
Constant Intermittent Variable
<u>Pain Range (24 hrs):</u>
Best: Current: Worst:

<u>Quality:</u>
<u>Aggr:</u>
<u>Ease:</u>
<u>24 hour:</u>
<u>Irritability:</u>