



Patients Name: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_ Phone: \_\_\_\_\_

Employed: Full Time: \_\_\_\_\_ Part Time: \_\_\_\_\_ Unemployed: \_\_\_\_\_ Retired: \_\_\_\_\_ Homemaker: \_\_\_\_\_ Student: \_\_\_\_\_ Other: \_\_\_\_\_

Referred By: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

Dominant Hand: Right: \_\_\_\_\_ Left: \_\_\_\_\_

Have you received Physical Therapy treatment this year? No / Yes When: \_\_\_\_\_ Where: \_\_\_\_\_

Are You Pregnant? No \_\_\_\_\_ Yes \_\_\_\_\_ Due Date: \_\_\_\_\_

**Medical History: Check all that Apply**

Arthritis: \_\_\_\_\_ Broken Bones/ Fractures: \_\_\_\_\_ Cancers: \_\_\_\_\_ Diabetes: \_\_\_\_\_ Heart Problems: \_\_\_\_\_

Lung Problems: \_\_\_\_\_ Osteoporosis \_\_\_\_\_ High Blood Pressure: \_\_\_\_\_ Parkinson's Disease \_\_\_\_\_ Stroke: \_\_\_\_\_

Head Injury: \_\_\_\_\_ Multiple Sclerosis: \_\_\_\_\_ Seizures: \_\_\_\_\_ Muscular Dystrophy: \_\_\_\_\_ Other: \_\_\_\_\_

**Are you having any of the following symptoms? Please check all that Apply**

Chest pains: \_\_\_\_\_ Loss of Balance: \_\_\_\_\_ Coordination Problems: \_\_\_\_\_ Pain at Night: \_\_\_\_\_

Difficulty Sleeping: \_\_\_\_\_ Visual Problems: \_\_\_\_\_ Headaches: \_\_\_\_\_ Weakness: \_\_\_\_\_

**History of Current Problems:**

Where is the area of pain / difficulty? \_\_\_\_\_

When did this develop? \_\_\_\_\_

How did this develop? \_\_\_\_\_

Has this ever happened before? \_\_\_\_\_

What makes it better? \_\_\_\_\_

What makes it worse? \_\_\_\_\_

**Current Limitations: Please check all that Apply**

Walking: \_\_\_\_\_ walking on rough ground: \_\_\_\_\_ Stairs: \_\_\_\_\_ Work / School: \_\_\_\_\_ Driving \_\_\_\_\_

Chores: \_\_\_\_\_ Shopping: \_\_\_\_\_ Recreational Activities: \_\_\_\_\_ Bathing: \_\_\_\_\_ Eating: \_\_\_\_\_ Dressing: \_\_\_\_\_

Prescription Medications: \_\_\_\_\_

Surgical History: \_\_\_\_\_

I will advise the Therapist if there are any changes in my physical condition that would alter my response to any of the above question.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_