1 **Name:**

____
Last

__________________ ______ _____________
First MI Jr/Sr

2 **Street Address:** _______________________

____
City State Zip

Phone #: _____________________________

If you live in FL only part of the year please provide the following:

Other Address: ___________________________

____
City State Zip

Other Phone #:___________________________

3 **Date of Birth:** __ __/__ __/ __ __ __ __
Month Day Year

4 **Sex:** Male Female

5 **Are you:** Right-handed Left-handed

6 **Type of Insurance 1º:**______________________

2º: ________________________ or Self-Pay

7 **Marital Status**

a) Single d) Widowed
b) Married e) Life Partner
c) Separated f) Divorced

8 **Employment Status**

a) Full-time d) Self-Employed
b) Part-time e) Student
c) Not Employed f) Retired

If retired date of your retirement
______ / ______ / __________
Month Date Year

g) Occupation _______________________________

9 **With whom do you live?**

a) Alone
b) Spouse
c) Other: __________________________________

10 **Who referred you to the physical therapist?**

____

11 **LIVING ENVIRONMENT**

Does your home have: **or** **Do you use:**

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

a) Cane
b) Walker
c) Manual wheelchair
d) Motorized wheelchair
e) Glasses, hearing aids
f) Other: _____________

12 **Where do you live?**

a) Home
b) Apartment
c) Condo
d) Other:______________________________

13 **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 the past year?
(ex. Move, job change, death of a family member)
(1)Yes (2)No

14 **SOCIAL/HEALTH HABITS**

a) Smoking
(1) Currently smoke tobacco (a) Yes (b) No
If yes how many packs per day ______

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 man drinks do you have, on an average day? _________

c) Exercise
How many days per week do you exercise? _________
What do you do for exercise?_____________________

15 **Fall History** – within the past year have you fallen if yes was it more than once and where?

____
____

16 MEDICAL/SURGICAL HISTORY

a) Please check if you have ever had:

(1) Arthritis	(15) Parkinson disease
(2) Broken bones/fractures	(16) Seizures/epilepsy
(3) Osteoporosis	(17) Allergies
(4) Anemia	(18) Stroke
(5) Circulation problems	(19) Thyroid problems
(6) Heart problems	(20) Cancer
(7) High blood pressure	(21) Infectious disease (eg, tuberculosis, hepatitis)
(8) Asthma	(22) Kidney disease
(9) Emphysema/Bronchitis	(23) Repeated infections
(10) Diabetes	(24) Chemical dependency (ie alcoholism)
(11) Blood clots	(25) Depression
(12) Multiple Sclerosis	(26) Other: __________
(13) Skin diseases	
(14) Ulcers/stomach problems	

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	Day	Year
____________________________	_____ /	_____/	________
____________________________	_____ /	_____/	________
____________________________	_____ /	_____/	________
____________________________	_____/	______/	________

17 FAMILY HISTORY (Indicate whether mother, father, brother/sister been treated for any of these and at what age?)

Heart disease	Cancer
High Blood Pressure	Alcoholism
Stroke	Depression
Diabetes	Osteoporosis
Inflammatory Arthritis	Kidney disease

18 CURRENT CONDITION(S)/ CHIEF COMPLAINT(S)

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

____

b) When did problem(s) begin _____ / _____ / ________

Month Day Year

c) What happened? ________________________________

____

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

(1)Yes (2)No

(i) If Yes, what did you do for the problem(s)?

____

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

(1) Yes (2) No

e) What makes the problem(s) better and worse?

____

f) What are your goals for physical therapy?

____

h) Are you seeing anyone else for the problem(s)? (check all that apply.)

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

Date of your last physical Exam? ______________

19 HOSPITALIZATIONS

Have you been in a HOSPITAL recently? (please give dates)

From _____ / _____ / ______ to _____ / _____ / ______

Month Day Year Month Day Year

20 HOME HEALTH CARE

a) Do you currently have health care even if only nursing?

(1)Yes (2) No

b) If No have you had it recently? (1)Yes

Discharge Date_____________________

21 MEDICATIONS (Provide list if needed)

Ex. Tylenol Daily 200mg

1. ____
2. ____
3. ____

22 NON-PRESCRIBED /HERBALS

Do you take any of these?

a)Advil/Aleve	f)Decongestants
b)Antacids	g)Herbal supplements
c)Ibuprofen/Naproxen	h)Tylenol
d)Antihistamines	i)Laxatives
e)Vitamins	j)Other _______________

23 OTHER CLINICAL TESTS- within the past year, have you had any of the following tests? (Check all that apply.)

(a) Arthroscopy
(b) Blood tests
(c) Bone scan
(d) CT scan
(e) MRI
(f) X-ray
(g) Other____________________________________