PIKE CREEK PHYSICAL THERAPY

To ensure you receive a complete and thorough evaluation, please provide us with the important background information on the following form. If you do not understand a question leave it blank and your therapist will assist you. Thank you!

NAME: _____DATE OF BIRTH: _____

ALLERGIES: List any medication(s) you are allergic to: _____
Are you latex sensitive? Yes No List any other allergies we should know about _____
Have you declared the Advanced Clinic Directive of Do Not Resuscitate? Yes No

Date of last visit with primary care provider/medical doctor: _____

Height:_____Weight:_____lbs.

Circle Yes or No...

Have you or any immediate family member ever been told you have.....

	Self		Family	
Cancer?	Yes	No	Yes	No
Diabetes?	Yes	No	Yes	No
High Blood Pressure?	Yes	No	Yes	No
Heart Disease?	Yes	No	Yes	No
Stroke?	Yes	No	Yes	No
Osteoporosis?	Yes	No	Yes	No
Osteoarthritis?	Yes	No	Yes	No
Rheumatoid Arthritis?	Yes	No	Yes	No
Circulation Problems?	Yes	No	Yes	No
Thyroid Problems?	Yes	No	Yes	No
Multiple Sclerosis?	Yes	No	Yes	No
Blood Clots?	Yes	No	Yes	No

Other _____

Do you or have you in the past smoked tobacco?
If yes, _____packs/day x _____ Years
Last tobacco use _____

Do you drink alcoholic beverages?
If yes, how many drinks do you routinely have per week? _____/week.

Do you currently have:

Anxiety/Depression?	Yes	No
Cancer?	Yes	No
Neurological Condition?	Yes	No
Cardiovascular Condition?	Yes	No
Chronic Lung Disease?	Yes	No

Prescribed Medications:_____
_____
_____
_____
_____
_____
_____

Over the Counter Medications:

____Aspirin _____Tylenol
____Advil/Aleve/Ibuprofen _____Laxatives
____Decongestants _____Vitamins/Minerals
____Antacid _____Antihistamines
Other:

Circle Yes or No...

In the past 3 months have you had or do you experience:

Nausea/vomiting?	Yes	No
Fever/chills/sweats?	Yes	No
Unexplained weight change?	Yes	No
Numbness or tingling?	Yes	No
Changes in appetite?	Yes	No
Difficulty in swallowing?	Yes	No
Changes in bowel or bladder function?	Yes	No
Shortness of breath?	Yes	No
Dizziness?	Yes	No
Upper Respiratory Infection?	Yes	No
Urinary Tract Infection?	Yes	No
Change in your balance? (incr. falls)	Yes	No
Fatigue/weakness?	Yes	No
Double vision/loss of vision?	Yes	No
Arm/leg swelling?	Yes	No
Blood in stools/urine?	Yes	No
Recent falls?	Yes	No

Circle Yes or No

Do you have a history of:

Allergies/Asthma	Yes	No
Headaches?	Yes	No
Bronchitis?	Yes	No
Kidney Disease?	Yes	No
Rheumatic Fever?	Yes	No
Ulcers?	Yes	No
Seizures/tremors?	Yes	No
Hepatitis?	Yes	No
Tuberculosis?	Yes	No

Surgeries (Date and reason):
_____
_____
_____
_____
_____

Circle the activity that <u>best</u> describes your occupation:
Sitting Standing Walking Lifting

Leisure Activities: _____
_____
_____

Patient's Goals:_____
_____
_____

Pain Diagram and Pain Rating

Name:_____ Date:_____ Date of Birth:_____

Please use the diagram below to indicate the symptoms you have experience over the past 24 hours. Use the key to indicate the type of symptoms.

Key: Pain=XXXXXXXXX Numbness or Pins and Needles=00000000000 Weakness=/ / / / / / / / / /

_____

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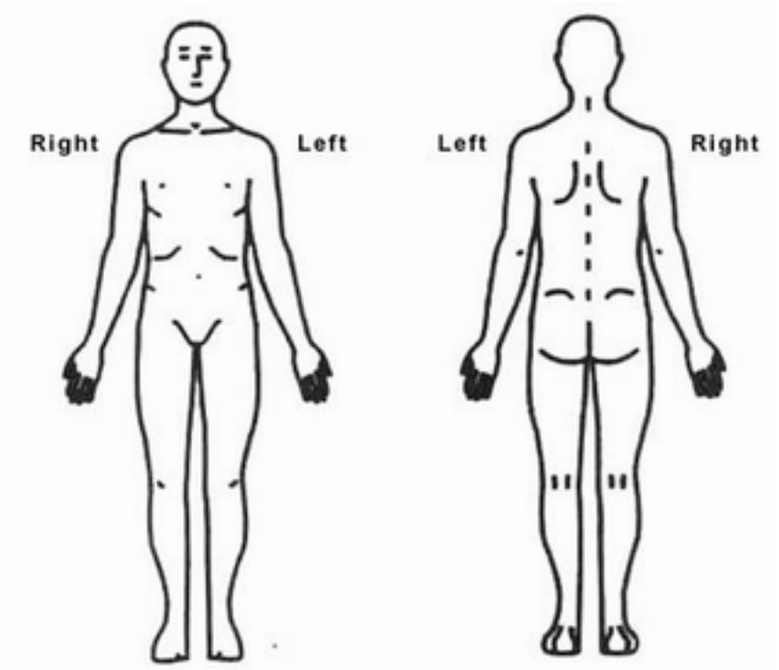

_____

Please rate your **worst level** of pain on the following scale: (circle one): 0=no pain, 10=worst pain imaginable

0 1 2 3 4 5 6 7 8 9 10

Please rate your **current level** of pain this episode: (circle one): 0=no pain, 10=worst pain imaginable

0 1 2 3 4 5 6 7 8 9 10

Please rate your **best level** of pain this episode: (circle one): 0=no pain, 10=worst pain imaginable

0 1 2 3 4 5 6 7 8 9 10

Symptoms began on: _____/_____/_____

Please circle which best describes the quality of your pain:

Burning Dull/Achy Sharp Throbbing Shooting

Patient Signature:_____Date:_____

Therapist Signature:_____Date:_____