PATIENT INFORMATION

Name______________________________ Date of Birth _________________ Date ________________

MEDICAL/SURGICAL HISTORY

Circle all that apply: Arthritis Blood Pressure High / Low Breaks/fractures Cancer Diabetes
Head Injury Heart conditions Pacemaker / Defibrillator Circulatory problems
Osteoporosis MS MD Parkinson's Seizure / Epilepsy Neuropathy
Headache / Migraine Joint Replacement HIP / KNEE / SHOULDER
OTHER ____

Vertigo / Dizziness Loss of balance / Falls Shortness of breath Difficulty sleeping
Changes in bowel / bladder control Vision problems Hearing loss Ringing in ears
Coordination problems Unexplained Weight loss Difficulty walking Swelling

Recent or Major surgeries (include dates) ____
____

Reason for seeking Physical Therapy / Occupational Therapy treatment: _________________________
____

How do you rate your pain level on a 0 -10 scale? (0 is no pain and 10 is the worse pain) ______/10.

Have you had treatment for this problem in the past? YES / NO
Type of treatment: ____

HOME:
Circle all that apply: Stairs Handrails R / L Carpeting Tile / Wood flooring Throw rugs
Ramps Safety Bars Location of safety bars _____________________________

Others living in the home ____

FUNCTIONAL LIMITATIONS: Walking tolerance ___________ minutes
Standing tolerance ______minutes Sitting tolerance_______minutes

Activities you are currently unable to perform or have difficulty with: (Mark with U for unable or D for difficulty)
_____Driving ______Backing car out _____Working _____Household chores ____Lifting
_____Reading ______Writing ____Sitting ____Standing _____Walking ___Computer work
_____Reaching overhead ____Reaching behind back ____Kneeling _____Bending ___Gardening
_____ADL's (bathing, grooming, hygiene) _____ Dressing _____ Shoes & Socks (ON /OFF)
_____Getting out of chair ______Getting out of car _____Getting in to / out of Bed
_____Sports (list all sports that apply) ____