Borger Physical Therapy

Name:______________________ Today's Date:__________

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:

Cultural/Religious: Any customs or religious beliefs or wishes that might affect care?

Employment/Work (Job/School/Play)

- □ Working full-time outside of home
- □ Working part-time outside of home
- □ Working full-time from home
- □ Working part-time from home
- □ Homemaker □ Student □ Retired □ Unemployed

LIVING ENVIRONMENT

Does your home have:

- □ Stairs, no railing
- □ Stairs, railing
- □ Ramps
- □ Uneven terrain
- □ Assistive devices (eg, bathroom) ______
- □ Any obstacles: ______

Do you use:

- □ Cane
- □ Walker
- □ Manual wheelchair
- □ Motorized wheelchair
- □ Glasses, hearing aids
- □ Other ______

GENERAL HEALTH STATUS

Please rate your health:

□ Excellent □ Good □ Fair □ Poor

Have you had any major life changes during past year: (eg, new baby, job change, death of a family member) □Yes □ No

SOCIAL/HEALTH HABITS

Smoking

Currently smoke tobacco? □ Yes □ Cigarettes: # of packs per day ____ □ Cigars/Pipes: # per day _____
□ No

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

Alcohol

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

If one beer, one glass of wine, or one cocktail equals one drink, how many drinks do you have, on an average day? _____

Exercise

Do you exercise beyond normal daily activities and chores?

□ Yes □ No ______

FAMILY HISTORY (Include whether mother, father, brother/sister, aunt/uncle, or grandmother/grandfather, and age of onset if known)

Heart disease:______

Hypertension:______

Stroke:______

Diabetes:______

Cancer:______

Psychological:______

Arthritis:______

Osteoporosis:______

Other:______

MEDICAL/SURGICAL HISTORY

Please check if you have ever had:

- □ Arthritis
- □ Broken bones/fractures
- □ Osteoporosis
- □ Blood disorders
- □ Circulation/vascular problems
- □ Heart problems
- □ Pace maker
- □ High blood pressure
- □ Lung problems
- □ Stroke
- □ Diabetes/high blood sugar
- □ Low blood sugar/hypoglycemia
- □ Head injury
- □ Ulcers/stomach problems
- □ Depression
- □ Multiple Sclerosis
- □ Muscular dystrophy
- □ Parkinson disease
- □ Seizures/epilepsy
- □ Allergies
- □ Developmental or growth problems
- □ Thyroid problems
- □ Cancer
- □ Infectious disease (eg, tuberculosis, hepatitis)
- □ Kidney problems
- □ Repeated infections
- □ Skin diseases
- □ Other: ______

Have you ever had surgery? □ Yes □ No

If yes please describe, and indicate dates: Month - Year

______ -
______ -
______ -
______ -
______ -
______ -

OVER - PLEASE COMPLETE BACK SIDE ➔

Within the past year have you had any of the following symptoms?
(Check all that apply)

- ☐ Chest pain
- ☐ Heart palpitations
- ☐ Cough
- ☐ Hoarseness
- ☐ Shortness of breath
- ☐ Dizziness or blackouts
- ☐ Coordination problems
- ☐ Weakness in arms or legs
- ☐ Loss of balance
- ☐ Difficulty walking
- ☐ Joint pain or swelling
- ☐ Pain at night
- ☐ Difficulty sleeping
- ☐ Loss of appetite
- ☐ Nausea/vomiting
- ☐ Difficulty swallowing
- ☐ Bowel problems
- ☐ Weight loss/gain
- ☐ Urinary problems
- ☐ Fever/chills/sweats
- ☐ Headaches
- ☐ Hearing problems
- ☐ Vision problems
- ☐ Other: ____________

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

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: ____________

____

CURRENT CONDITION(S)/CHIEF COMPLAINT(S)

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

____

____

When did the problem(s) begin (date)? Month - Year ___ - ___

What happened? ____________

____

Have you ever had the problem(s) before?

☐ Yes

What did you do for the problem(s)? ____________

____

Did the problem(s) get better? ☐ Yes ☐ No

About how long did the problem(s) last? ____________

☐ No

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

____

What makes the problem(s) better? ____________

____

What makes the problem(s) worse? ____________

____

What are your goals for physical therapy? ____________

____

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

- ☐ Acupuncturists
- ☐ Cardiologist
- ☐ Chiropractor
- ☐ Dentist
- ☐ Family practitioner
- ☐ Internist
- ☐ Massage therapist
- ☐ Neurologist
- ☐ Obstetrician/gynecologist
- ☐ Occupational therapist
- ☐ Orthopedist
- ☐ Osteopath
- ☐ Pediatrician
- ☐ Podiatrist
- ☐ Primary Care Physician
- ☐ Rheumatologist
- Other: ____________

MEDICATIONS

Do you take any prescription medications? ☐ Yes ☐ No

If yes, please list: ____________

____

☐ List attached on separate sheet

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

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

Have you taken any medications previously for the condition for which you are seeking the physical therapist? ☐ Yes ☐ No

If yes, please list: ____________

Do you have allergies to any of the following:

- ☐ Topical ointments
- ☐ Latex
- ☐ Lotions
- ☐ Other: ____________

Are you sensitive to:

Heat	☐ Yes	☐ No
Cold	☐ Yes	☐ No

OTHER CLINICAL TEST

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 velocity)
- ☐ Pap smear
- ☐ Pulmonary function test
- ☐ Spinal tap
- ☐ Stool test
- ☐ Stress test (eg, treadmill, bicycle)
- ☐ Urine tests
- ☐ X-rays
- ☐ Other: ____________

"Adapted with permission of the American Physical Therapy Association from *Interactive Guide to Physical Therapist Practice With Catalog of Test and Measures*, Version 1.0. Alexandria, Va: American Physical Therapy Association; 2002."