Beyond Physical Therapy, PLLC

Patient Name: _____ Date: __ __ / __ __ / __ __

If you have a pain please mark factors aggravating and relieving pain:
(+) aggravating, (-) reliving.

	Sleep/rest		Cold		Movement		Exercise
	Urination/defection		Weather changes		No movement		Lying down
	Eating		Massage		Sitting		Intercourse
	Heat		Pressure		Standing		Working

FAMILY/PERSONAL HISTORY

Family History

Have you or any immediate family member (parent, sibling, child) ever been told you have:

Circle one:			Relation to Client
• Angina or chest pain	Yes	No	
• Cancer	Yes	No	
• Diabetes Type I Type II	Yes	No	
• Heart attack	Yes	No	
• Hemophilia/slow healing	Yes	No	
• High cholesterol	Yes	No	
• Hypertension or high blood pressure	Yes	No	
• Stroke	Yes	No	

Personal History

Have you ever had?

• Eating disorder (bulimia, anorexia)	Yes	No	• Chronic bronchitis	Yes	No
• Epilepsy/seizures	Yes	No	• Emphysema	Yes	No
• Fibromyalgia/myofascial pain	Yes	No	• GERD	Yes	No
• Osteoporosis	Yes	No	• Gout	Yes	No
• Hepatitis/jaundice	Yes	No	• Guillain-Barré Syndrome	Yes	No
• Hypoglycemia	Yes	No	• Arthritis	Yes	No
• Joint replacement	Yes	No	• Parkinson's disease	Yes	No
• Polio/postpolio	Yes	No	• Peripheral vascular disease	Yes	No
• Shortness of breath	Yes	No	• Allergies	Yes	No
• Skin problems	Yes	No	• Pneumonia	Yes	No
• Rheumatic/scarlet fever	Yes	No	• Prostate problems	Yes	No
• Depression	Yes	No	• Ulcer/stomach	Yes	No
• Cirrhosis/liver disease	Yes	No	• Thyroid problems	Yes	No
• Urinary tract infection	Yes	No	• Headaches	Yes	No
• Anemia	Yes	No	• Multiple Sclerosis	Yes	No
• Kidney disease/stones	Yes	No	• Anxiety/Panic attacks	Yes	No

• Asthma, hay fever, or other breathing problems Yes No
• Urinary incontinence (dribbling, leaking) Yes No

For women:

History of endometriosis Yes No
History of pelvic inflammatory disease Yes No
Are you/could you be pregnant? Yes No
Any trouble with leaking or dribbling urine? Yes No
Number of pregnancies _____ Number of live births _____
Have you ever had a miscarriage/abortion? Yes No

General Health:

1. I would rate my health as (circle one): Excellent Good Fair Poor
2. Have you had any illnesses within the last 3 weeks (e.g., colds, influenza, bladder or kidney infection)? Yes No
   If yes, have you had this before in the last 3 months? Yes No
3. Have you noticed any lumps or thickening of skin or muscle anywhere on your body? Yes No
4. Do you have any sores that have not healed or any changes in size, shape, or color of a wart or mole? Yes No
5. Have you had any unexplained weight gain or loss in the last month? Yes No
6. Do you smoke or chew tobacco? Yes No
   If yes, how many packs/pipes/pouches/sticks a day? _____
7. I used to smoke/chew but I quit Yes No
   If yes: pack or amount/day _____ Yes No
8. How much alcohol do you drink in the course of a week? (one drink is equal to 1 beer, 1 glass of wine or 1 shot of hard liquor) _____
9. Do you use recreational or street drugs (marijuana, cocaine, crack, meth, amphetamines, or others)? If yes, what, how much, how often? Yes No
   _____
10. Are you on any special diet? Yes No

□ Blood in urine, stool, mucous
□ Dizziness, fainting, blackouts
□ Fever, chills, sweats (day or night)
□ Nausea, vomiting, loss of appetite
□ Changes in bowel or bladder
□ Unusual fatigue, drowsiness
□ Sudden weakness
□ Difficulty swallowing/speaking
□ Throbbing sensation/pain in belly or anywhere else
□ Cough
□ Trouble sleeping
□ Heart palpitations or fluttering
□ Numbness or tingling
□ Confusion
□ Problems seeing or hearing
□ Unusual fatigue, drowsiness
□ Memory loss
□ None of these

Medical/Surgical History

1. Have you ever been treated with chemotherapy, radiation therapy, biotherapy, or brachytherapy (radiation implants)? Yes No
   If yes, please describe:
2. Have you had any x-rays, sonograms, computed tomography (CT) scans, or magnetic resonance imaging (MRI) or other imaging done recently? Yes No
   If yes, what? When? Results?
3. Have you had any laboratory work done recently (urinalysis or blood tests)? Yes No
   If yes, what? When? Results?
4. Any other clinical tests? Yes No
   Please describe:
5. Please list any operations that you have ever had and the date(s): Yes No

Operation	Date

6. Do you have a pacemaker, transplanted organ, joint replacement, breast implants, or any other implants? Yes No
   If yes, please describe:

Work/Living Environment

1. Does your work involve:
□ Prolonged sitting (e.g., desk, computer, driving)
□ Prolonged standing (e.g., equipment operator, sale clerk)
□ Prolonged walking (e.g., mill worker, delivery service)
□ Use of large or small equipment (e.g., telephone, forklift, computer, drill press, cash register)
□ Lifting, bending, twisting, climbing, turning
□ Exposure to chemicals, pesticides, toxins, or gases
□ Other: please describe _____
□ Not applicable; none of these

2. Do you use any special supports:
□ Back cushion, neck cushion
□ Back brace, corset
□ Other kind of brace or support for any body part
□ None; not applicable

History of falls:

□ I have had no falls
□ In the past year
□ I have just started to lose my balance/fall.
□ I fall occasionally.
□ I fall frequently (more than two times during the past 6 months).
□ Certain factors make me cautious (e.g., curbs, ice, stairs, getting in and out of the tub).

I live:

□ Alone □ With family, spouse, partner □ Nursing home □ Assisted Living
□ Other _____

Dwelling: □ Apartment □ House □ Trailer □ Stairs □ Steep driveway

Transportation: □ Self drive □ Public transportation □ Friends/ family drive me

Did you participate in Physical Therapy:

□ No;
□ Yes, for my current condition
□ Yes, but not for my current condition Explain, what have you been seen for:
_____

Are you taking any prescription or over-the-counter medications? Yes No

If yes, please list: