

MEDICAL HISTORY

Survey Date: _____

Last Name: _____ First Name: _____

Reason for Referral: _____

Current Condition

Height: _____ FT. _____ IN.

Weight: _____ LBS.

Pregnant? _____ (Y/N)

Currently on Medication? _____ (Y/N)

List Medications: _____

Do you drink alcoholic beverages? _____ (Y/N)

Per Day: _____ Per Week: _____

List Allergies: _____

Describe your general health: (choose one)

Excellent _____ Good _____ Fair _____ Poor _____

Do you use any assistive devices? _____ (Y/N) Cardiovascular Fitness: (Choose One)

List Devices: _____ Aerobic Activity 3-5 days week

Do You Smoke Cigarettes? _____ (Y/N) Occasional Recreation activities at

Packs Per Day _____ least 4 times a month

_____ Sedentary Life-style

HISTORY

Have you ever had any of the following? (Check all that apply)

- | | | | |
|-------------------------------------|---|---|------------------------------------|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Headaches | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Shortness |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> of Breath |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Low Blood Press. | <input type="checkbox"/> Stoke |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Heart Palpitations | <input type="checkbox"/> Metal Implants | <input type="checkbox"/> Swollen |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Ankles |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Hernia | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Other |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> High Blood Press. | <input type="checkbox"/> Rheumatoid arthritis | |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> HIV | <input type="checkbox"/> Tuberculosis | List: _____ |
| <input type="checkbox"/> Fractures | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Seizures | |

List surgeries with date: _____

OBJECTIVES:

Primary reasons for attending therapy: (check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Pain | <input type="checkbox"/> Activity Reduction |
| <input type="checkbox"/> Limited Motion | <input type="checkbox"/> Loss of Independence |
| <input type="checkbox"/> Weakness | <input type="checkbox"/> Unable to Work |
| <input type="checkbox"/> Injury | <input type="checkbox"/> Unable to do Household Tasks |
| <input type="checkbox"/> Surgery | <input type="checkbox"/> Unable to Play Sports or Recreations |

What are your personal goals for therapy: (choose 4 that are most important)

- | | |
|---|--|
| <input type="checkbox"/> Decrease Pain | <input type="checkbox"/> Regain Mobility/Flexibility |
| <input type="checkbox"/> Learn Self-Care Techniques | <input type="checkbox"/> Increase Strength |
| <input type="checkbox"/> Resume/Improve Household Chores | <input type="checkbox"/> Increase Sitting tolerance |
| <input type="checkbox"/> Resume/Improve Gardening | <input type="checkbox"/> Increase Walking Distance/Speed |
| <input type="checkbox"/> Return to Work Activities | <input type="checkbox"/> Improve Posture |
| <input type="checkbox"/> Return to Sports | <input type="checkbox"/> Improve Sleep |
| <input type="checkbox"/> Improve Self-Care (dressing, hair) | <input type="checkbox"/> Improve Body Mechanics |