

Office Use Only
Date PT/OT eval:
MRN:

Patient's Name (First, Middle, Last)	Referring physician: Date of next appointment:
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Reason for Visit (Describe Injury):	Goal (What do you want to do better with therapy?):	Date of Onset:
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Onset/Timing: Number of Prior Episodes: Gradual Onset Sudden Onset

How did your pain/problem start? Unknown While Lifting Car Accident A Fall
 Trauma Overuse Degenerative Process Recreation/Sport: Dental Appt
 Other:

Severity of pain/problem: Improving Not Changing Worse

Describe your pain/symptoms: Sharp Dull Throbbing Aching
 Periodic Occasional Constant Painful/Stiff when getting out of bed
 Other:

Throughout the day, my pain/problem: Increases Decreases Stays the same

Wake up at night when: lying still changing positions lying still and changing positions

Sleeping Position: Back, sides and stomach on right side on left side
 on stomach on back chair/recliner

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

<input type="checkbox"/> Unable to control bowel/bladder	<input type="checkbox"/> Fever/Chills	<input type="checkbox"/> Numbness of Genitalia	<input type="checkbox"/> Numbness
<input type="checkbox"/> Dizziness/Fainting	<input type="checkbox"/> Unexplained Weakness	<input type="checkbox"/> Unexplained change in weight	<input type="checkbox"/> Night Pain/Sweats
<input type="checkbox"/> Malaise	<input type="checkbox"/> Vision Problems	<input type="checkbox"/> Hearing Problems	
<input type="checkbox"/> Other:			

Aggravating Factors (check all that apply):

<input type="checkbox"/> Sitting	<input type="checkbox"/> Going to/raising from sitting	<input type="checkbox"/> Walking	<input type="checkbox"/> Up/Down Stairs	<input type="checkbox"/> Lying Down
<input type="checkbox"/> Looking Up Overhead	<input type="checkbox"/> Reach Overhead	<input type="checkbox"/> Reach In Front	<input type="checkbox"/> Reach Behind Back	<input type="checkbox"/> Reach Across Body
<input type="checkbox"/> Repetitive Activity	<input type="checkbox"/> Household Activities	<input type="checkbox"/> Sports/Recreation	<input type="checkbox"/> Standing	<input type="checkbox"/> Squatting
<input type="checkbox"/> Sustained Bending	<input type="checkbox"/> Cough	<input type="checkbox"/> Deep Breathing	<input type="checkbox"/> Sleeping	<input type="checkbox"/> Talking
<input type="checkbox"/> Chewing	<input type="checkbox"/> Swallowing	<input type="checkbox"/> Yawning	<input type="checkbox"/> Stress	
<input type="checkbox"/> Other:				

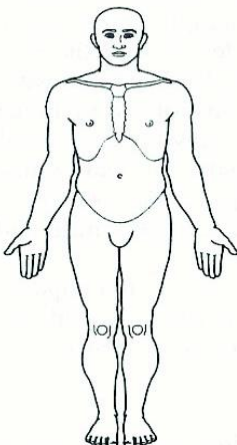
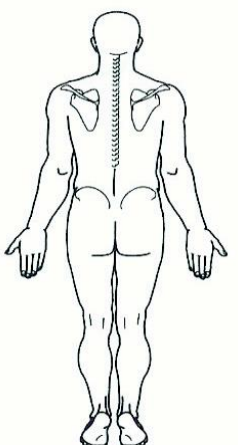
Alleviating Factors (check all that apply):

<input type="checkbox"/> Rest	<input type="checkbox"/> Cold	<input type="checkbox"/> Nothing	<input type="checkbox"/> Medication	<input type="checkbox"/> Wearing a splint/orthotics
<input type="checkbox"/> Walking	<input type="checkbox"/> Lying Down	<input type="checkbox"/> Heat	<input type="checkbox"/> Sitting	<input type="checkbox"/> Standing
<input type="checkbox"/> Other:		<input type="checkbox"/> Stretching	<input type="checkbox"/> Exercise	<input type="checkbox"/> Massage

Pain is: Constant Intermittent Variable in Intensity Activity Dependent

Current pain: /10 Highest pain in past 2 weeks: /10 Lowest pain in past 2 weeks: /10

Please map your areas of discomfort or altered sensation on the body map.
 XXX = Pain
 000 = Numb/Tingle/Radiating
 *** = Weakness

MEDICAL/SURGICAL HISTORY: a. Please check all that apply

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|-------------------------------------------------|----------------------------------------------|----------------------------------------|------------------------------------------------|-------------------------------------------------|
| <input type="checkbox"/> ADD | <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Falls | <input type="checkbox"/> Lymphedema | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Brain Injury | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Neurological Disorder | <input type="checkbox"/> Peripheral Vascular |
| <input type="checkbox"/> Allergies/Hayfever | <input type="checkbox"/> Cancer | <input type="checkbox"/> Head Injury | <input type="checkbox"/> Neuropathy | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Ankylosing spondylitis | <input type="checkbox"/> Carpal Tunnel | <input type="checkbox"/> Headaches | <input type="checkbox"/> Meniere's Disease | <input type="checkbox"/> Serious Illness/Injury |
| <input type="checkbox"/> Anxiety/Depression | <input type="checkbox"/> Cystic Fibrosis | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Muscle/Bone Problem | <input type="checkbox"/> Skin Sensitivities |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Developmental Delay | <input type="checkbox"/> Hernia | <input type="checkbox"/> Neck Injury | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Obesity | <input type="checkbox"/> Urinary Problems |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Orthotics | <input type="checkbox"/> Vertigo |

Surgery History: (please list & include dates (mo/year):

MEDICATIONS: Do you take prescription or nonprescription medication? YES, NO If yes, please list below or attach a list.

Prescription	Non-prescription
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ALLERGIES: Do you have any allergies? None Bees Latex Perfumes/lotions Coconut pine/linden
 Adhesive/tapes Other (please specify):

(We use various emollients and tapes, please feel free discuss ingredients with therapists.)

SOCIAL HISTORY:

Smoking Status: Never Former Current Everyday Current Some Day Smoker – Status Unknown

Employment/Work (job/school)	<input type="checkbox"/> Full time	<input type="checkbox"/> Part time	<input type="checkbox"/> Retired	<input type="checkbox"/> Student	<input type="checkbox"/> Unemp loyed	<input type="checkbox"/> Disability
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Occupation:	Sports/Hobbies:
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Exercise Level: None Occasional Moderate Heavy
(Please include type of exercise, days/wk, and average # minutes)

Marital Status: Unknown Married Single Divorced Separated Widowed Domestic Partner # of Children:

Living Status: Alone Live with others Pet(s): (please specify)

Single/Multi-level home/work: Single-level home Multi-level home Single-level work Multi-level work

of Entry steps:
FRONT: ____ (handrail YES, NO) Garage: ____ (handrail YES, NO) Second Floor: ____ (handrail YES, NO)
BACK: ____ (handrail YES, NO) Basement: ____ (handrail YES, NO) Other Issues:

Do you use any of the following assistive devices/orthotics?
 Cane (single point, quad) Walker (type: _____) Wrist braces/splints
 Crutches Manual/ Power wheelchair or cart Ankle foot orthosis (AFO)
 Foot orthotics (how old? _____)

Work Related Injury: Yes No Auto Related Injury: Yes No

Able to care for self: Yes No (if no, who cares for you?)

Home Therapy: Are you currently receiving health care services in your home that are billed to your insurance?
 Yes No

Please rate these activities on a scale 0-10 (0=can perform easily and 10 =cannot do at all) because of your problem

- | | | | | |
|-------------------------------|-------------------|------------------|--------------------|--------------|
| 1. Sleep through night ____ | 2. Self care ____ | 3. Sit ____ | 4. Stand ____ | 5. Walk ____ |
| 6. Ascend/descend stairs ____ | 7. Lift ____ | 8. Reach ____ | 9. Work tasks ____ | |
| 10. Other: _____ | 11: Other: _____ | 12. Other: _____ | | |

Patient signature:

Date:

Therapist Signature:

Date:

