

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  
**Current Pain: \_\_\_/10      Highest pain in past 2 weeks: \_\_\_/10      Lowest pain in past 2 weeks: \_\_\_/10**

Pain is:  Constant  Intermittent  Variable in Intensity  Activity Dependent

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:			

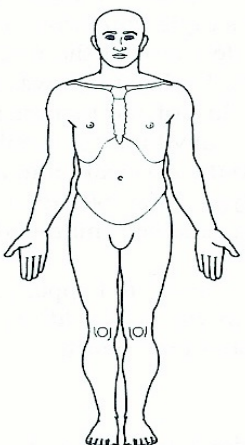
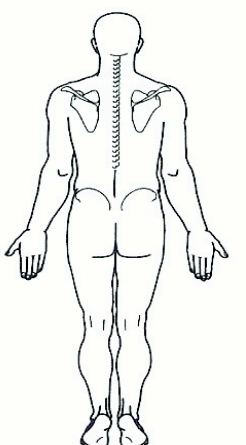
**Aggravating Factors (check all that apply):**

<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

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

- |   |  |  |  |   |
|---|--|--|--|---|
| <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)  Full time  Part time  Retired  Student  Unemployed  Disability

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: \_\_\_\_\_

Are you interested in learning more about the following services:  Nutrition/Weight Management  Sports Psychology  
 Fitness Testing (VO2 Max, Resting Metabolic Rate, etc)  Athletic Enhancement Program  Injury/Fall Prevention

**Patient signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Therapist Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_