

The information you provide is very important to your health and will help our staff determine the care you need as well as any further assessments. Please take time to fully and completely fill out this very important information. **NOTE: If you are currently receiving any type of home health care services, please see the receptionist before completing this form.**

GENERAL INFORMATION:

NAME:			DATE OF BIRTH:
HOME #:	CELL #:	WORK #:	EMERGENCY CONTACT#:
EMAIL ADDRESS:		ONSET DATE OF SYMPTOMS:	
REFERRING PHYSICIAN:		PRIMARY CARE PHYSICIAN:	

PLEASE ANSWER THE FOLLOWING QUESTIONS COMPLETELY

1. Reason for being referred to physical therapy / occupational therapy:

2. What do you expect to accomplish by attending therapy?

3. Check all that apply and explain the following medical problems that you have had:

- | | | | |
|---|--|---|---|
| ☐ AIDS/HIV | ☐ COPD | ☐ Kidney Disease | ☐ Rheumatoid Arthritis |
| ☐ Allergies | ☐ Dementia | ☐ Liver Disease | ☐ Seizures |
| ☐ Anemia | ☐ Diabetes | ☐ Motor Vehicle Accident | ☐ Shortness of Breath |
| ☐ Anxiety/Depression | ☐ Emphysema | ☐ Neuropathy | ☐ Sinusitis |
| ☐ Asthma | ☐ Fractures | ☐ Osteoarthritis | ☐ Stroke |
| ☐ Back Trouble | ☐ Heart Condition | ☐ Osteoporosis | ☐ Swelling Hands/Feet |
| ☐ Cancer | ☐ Hepatitis | ☐ Post-Polio Syndrome | ☐ Thyroid Disease |
| ☐ Chest Pain | ☐ High Blood Pressure | ☐ Psychiatric Treatment | ☐ Tuberculosis |

Explain as necessary:

4. List any operation or surgeries that you have had:

5. List any medications you are currently taking:

6. List any allergies and describe any drug reactions: _____
Are you allergic to latex? ☐ Yes ☐ No _____

7. Please check any of the following you may have/wear:

- ☐ Glasses ☐ Contacts ☐ Dentures ☐ Pacemaker ☐ Metal/Foreign Object Implant ☐ Hearing Aides

8. Are you pregnant? ☐ Yes ☐ No

9. Any significant weight gain/loss in the last year? ☐ Yes ☐ No If yes, (+, -) _____ lbs.

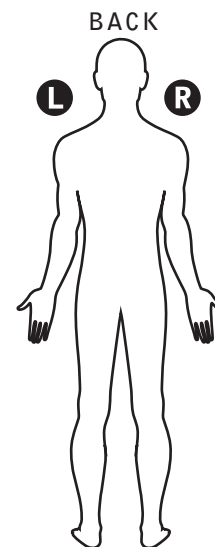
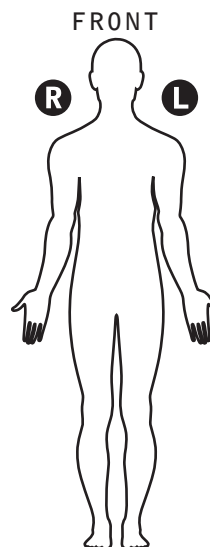
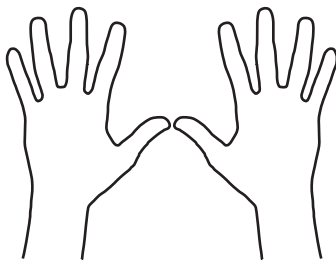
CURRENT MEDICAL CONDITION

If you indicated pain above, use the key below to indicate on the chart(s) the appropriate symptom(s) and area(s) where you are having the most pain.

PAIN INDICATOR

KEY

X = Sharp Sensation
O = Numbness or Tingling
= Dull Aching
+ = Burning Sensation
> = Radiating Pain



Worst Pain Level: _____ Current Pain Level: _____

Best Pain Level: _____ Acceptable Pain Level: _____



What makes symptoms better?

What makes symptoms worse?

How have the symptoms changed since onset: ☐ Better ☐ Worse ☐ No change

What special test have you had for this condition? (Mark below all that you've had and the dates completed)

☐ Cat Scan	☐ Injection	☐ Bone Scan	☐ Discogram	☐ EMG	☐ MRI	☐ X-ray
DATE: _____	DATE: _____	DATE: _____	DATE: _____	DATE: _____	DATE: _____	DATE: _____

Have you had therapy for this condition before? ☐ Yes ☐ No If yes, when and where?

Patient-specific activity scoring scheme

The information below is critical to obtain for insurance payment.

Please identify **at least three important activities** that you are unable to do or are **having difficulty with** as a result of your current problem/diagnosis (i.e. the reason your doctor has referred you to therapy). Today, are there any activities that you are unable to do or having difficulty with because of your problem/diagnosis?

Rate each of these problems on the 0-10 scale:

0 = Unable to perform activity (Cannot perform)

10 = Able to perform activity at the same level as before injury or problem (No Issues)

1. Activity:

0 1 2 3 4 5 6 7 8 9 10
CANNOT PERFORM NO ISSUES

2. Activity:

0 1 2 3 4 5 6 7 8 9 10
CANNOT PERFORM NO ISSUES

3. Activity:

0 1 2 3 4 5 6 7 8 9 10
CANNOT PERFORM NO ISSUES

4. Activity:

0 1 2 3 4 5 6 7 8 9 10
CANNOT PERFORM NO ISSUES

To the best of my belief, this information is true and correct.

PATIENT SIGNATURE

THERAPIST SIGNATURE