NAME: _____ **HEIGHT:** _____ **WEIGHT:** _____

Describe the problem(s) for which you seek therapy:

_____

_____

CHIEF COMPLAINTS(Check all that apply relative to your **CHIEF** complaint only)

___ Balance problems
___ Burn
___ Cough
___ Difficulty walking
___ Difficulty w/ daily activities
___ Dizziness
___ Falls/History of falls
___ Fatigue/Poor endurance
___ Headache
___ Impaired sensation
___ Joint stiffness
___ Joint swelling
___ Muscle tenderness
___ Muscle weakness
___ Numbness
___ Pain
___ Problems breathing / Shortness of breath
___ Tingling
___ Ulcer, Wound, or other Skin condition
___ Other 1:_____
___ Other 2:_____

If there is pain, specify type of pain (Check all that apply)

___ Ankle pain
___ Back pain
___ Chest pain
___ Elbow pain
___ Foot pain
___ Hand pain
___ Hip pain
___ Jaw pain
___ Knee pain
___ Lower extremity/Leg pain
___ Neck pain
___ Rib pain
___ Shoulder pain
___ Upper extremity/Arm pain
___ Wrist pain
___ Other: _____

HISTORY OF CURRENT COMPLAINT ONLY

When did the current problem(s) begin? (mm/dd/yyyy) _____/_____/_____ **Date of Injury**: _____/_____/_____

Describe the history of the current complaint(s):

_____

_____

How are you taking care of the current problem(s) now?_____

Related/Recent Hospitalization? YES / NO **Date of Hospitalization:** ____/____/_____ **Hospital Name:** _____

I am concerned about or have problems with: (Check all that apply)

___ Bed mobility
___ Climbing stairs
___ Coordination
___ Difficulty w/self care (bathing, dressing, toileting, etc.)
___ Flexibility
___ Grasping objects, lifting
___ Other _____
___ Performing home management (chores, shopping, care of dependents)
___ Performing job responsibilities/ Community activities (work, school…)
___ Performing sports, recreation, play activities
___ Reaching overhead
___ Repetitive movements (hand, arm, shoulder)
___ Sitting
___ Standing
___ Transfers (getting out of a chair, bed…)
___ Walking
___ Writing/grasping items with hand(s)

ASSOCIATED SURGERY – Have you had surgery related to this problem? YES / NO

Associated Surgery 1 - Date: _____/_____/_____ **Type of Surgery** _____
Associated Surgery 2 - Date: _____/_____/_____ **Type of Surgery** _____
Associated Surgery 3 - Date: _____/_____/_____ **Type of Surgery** _____

PAIN SCALE

When considering the amount of pain you have had over the last 24 hours, please use the scales below to indicate your pain level. 0 signifies NO pain while 10 is the worst pain you can imagine. The rating for **BEST** indicates the time when you have had the least amount of pain, while the **WORST** is when the pain has been most intense.

Please rate your pain level 0-10: (Circle **ONE** number on each pain scale)

BEST: 0 1 2 3 4 5 6 7 8 9 10 **WORST: 0 1 2 3 4 5 6 7 8 9 10** **PRESENT: 0 1 2 3 4 5 6 7 8 9 10**

Tolerance/Time:

Sit_____ **Stand** _____ **Walk** _____

What activities make your symptoms worse? _____

What activities make your symptoms better? _____

Difficulties at work?_____ **Difficulties with daily living?** _____

Difficulties with recreational activities? _____

Have you been diagnosed with any of the following conditions? (Check all that apply)

___Arthritis
___Asthma
___Blood disorder
___Broken bones/fractures
___Cancer
___Circulation/vascular problems
___COPD
___Deep vein thrombosis/PE
___Depression
___Developmental/growth problems
___Diabetes
___Eating disorder
___Emphysema
___Fibromyalgia
___GERD(reflux)
___Head injury
___Headaches
___Heart attack/MI
___Heart disease
___Hearing impairment
___Hypercholesteremia
___Hypertension (High BP)
___Infectious disease
___Kidney problems
___Liver disease
___Low back pain
___Low blood pressure
___Multiple Sclerosis
___Muscular Dystrophy
___Osteoarthritis
___Osteoporosis
___Parkinson's disease
___Peripheral neuropathy
___Psychiatric disorder
___Repeated infections
___Seizures/Epilepsy
___Spinal cord injury
___Skin diseases
___Stomach problems/Ulcers
___Stroke .
___Thyroid problems
___Vision impairment
___Other:_____
_____
_____

_____

*FALL RISK

Have you fallen in the past year? **YES / NO** **If yes, describe your injuries:** _____

Do you feel you are at risk for future falls? YES / NO

WOMENS HEALTH – Females *only* complete

Have you ever been diagnosed with? (Check all that apply)

_____ Complicated pregnancies/deliveries _____Endometriosis _____Pelvic Inflammatory Disease
_____ Trouble with your period _____Other gynecological/obstetrical difficulties

Are you pregnant? (Circle one answer) **YES / NO / UNSURE**

SURGICAL HISTORY - If no problems, check here _____. Otherwise complete the following:

Have you ever had surgery? YES / NO

Select which surgeries and enter date (mm/dd/yyyy): (Check all that apply)

_____ACL repair/reconstruction
_____Achilles tendon repair
_____Angioplasty
_____Aortic valve surgery
_____Appendectomy
_____Arthroscopic surgery- which joint?_____
_____Arthroscopic examination- which joint? _____
_____Back surgery
_____Bone marrow transplant
_____Bunionectomy
_____Coronary artery bypass graft
_____Caesarian section
_____Cardiac catheterization
_____Cardiac surgeries
_____Carpel tunnel release
_____Cholecystectomy (gallbladder removed)
_____Chondroplasty
_____Colon surgery
_____Colostomy
_____Femoral popliteal bypass
_____Gall bladder surgery
_____Gastric bypass surgery
_____Hand surgery
_____Heart transplant
_____Hernia repair
_____Hysterectomy
_____Joint replacement- which joint?_____
_____Kidney transplant
_____Lapband surgery
_____Liver transplant
_____Lumpectomy
_____Mastectomy
_____Neck surgery
_____**Pacemaker/Defibrillator insertion**
_____Plastic surgery
_____Rotator cuff repair
_____Splenectomy
_____Tracheotomy
_____Transurethral resection of prostate
_____ Other _____
_____

Do you have any of the following metals or plastics in your body? (Check all that apply)

_____Rod _____Pins _____Staples _____Artificial joints ____Metal from gunshot wound _____Pacemaker _____None _____Other

ALLERGIES, MEDS, TESTS

Have you ever had an allergy? (Check all that apply)

___Food Items ___Medications ___Dust ___Latex ___None ___Pets ___Pollen _____Other 1 _____Other 2

Comments/Allergies: _____

MEDICATIONS:

Are you taking any prescription medications? (Circle one) **YES / NO** *** Please complete medication list on the last page.**

Are you taking any non-prescription medications? YES / NO

Are you taking any anticoagulant medications? YES / NO

Are you taking any medication for ulcers? YES / NO

OTHER CLINICAL TESTS:

Within the last year, have you had any of the following tests for this CURRENT problem? (Check all that apply)

___Angiogram
___Blood tests
___Bone scan
___CT scan
___Colonoscopy
___Doppler ultrasound
___Echocardiogram
___EEG (Electroencephalogram)
___EKG (Electrocardiogram)
___EMG (Electromyogram)
___Mammogram
___MRI
___Myelogram
___NCV (nerve conduction velocity)
___Pap smear
___Pulmonary function test
___Spinal tap
___Urine test
___X-Rays
___Other:_____
_____

If yes, describe the results.

_____
_____

DIABETES – If not diabetic, check here_____. Otherwise complete the following:

Diabetes Mellitus: (Circle one answer) Type 1 IDDM (juv) NIDDM (Adult) **Duration of Diabetes (years):_____**

Current control: (Check all that apply) ____ Diet ____ Exercise ____Oral ___ Insulin ___Other:_____

Medical Conditions: (Check all that apply) ___MI ___CHF ___COPD ___CABG ___HTN ___Retinopathy ___Revascularized ____Renal Deficiency ____Menopause – Age: _____ ____Renal Dialysis – Duration (Mos.)_____ Other:_____

GENERAL HEALTH STATUS:

Please rate your general health: (Circle one answer) Excellent Very Good Good Fair Poor

Have you had any major life changes during the past year (i.e.: new baby, job change, death of a family member)? YES / NO

SOCIAL HEALTH HABITS:

Smoking:

Current tobacco use? YES / NO Date stopped using tobacco: _____ Smokeless tobacco user? YES / NO

Cigarettes: # of packs per day _____ Cigars / Pipes: per day _____ Smokeless Tobacco: # Dips / Chews per day_____

Tobacco use in the past? YES / NO If yes, number of years of tobacco use _____

WEIGHT CHANGE:

Have you experienced any recent weight change? (Circle one answer) Increase Decrease No Change **# of pounds_____**

Time frame of weight change _____ Period (Circle one answer) Days Weeks Months Years

Alcohol:

How many days per week do you drink beer, wine, or other alcoholic drinks?_____

If one beer, one glass of wine, or one cocktail equals one drink, how many drinks do you have on any average day?_____

NAME: _____ **DATE:** _____

List of Medications, Non-Prescription Medications, Vitamins, Herbs, Etc.

Medication	***Dosage***	***Frequency***

Thank You for choosing us as your Physical Therapy Team!
Please take a moment and let us know how you heard about us.

Name: _____
Email Address (please **PRINT**): _____
Date of appointment: _____

How did you hear about us? **(Please check all that apply)**

- ☐ Previous Patient
- ☐ Doctor's Office
- ☐ Family / Friend Who may we thank for the referral? _____
- ☐ Website (www.Westernberkspt.com)
- ☐ Insurance Company Specified
- ☐ Sign Outside / Drive by
- ☐ Internet Search (Google, Bing, Yelp, etc.)
- ☐ Social Media
  - ☐ Facebook
  - ☐ Twitter
  - ☐ Pinterest
  - ☐ Instagram
- ☐ Brochure
- ☐ Phonebook
- ☐ Postcard
- ☐ You Tube

*Other (please list specifics): _____

THANK YOU FOR HELPING US SERVE YOU BETTER!