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 dependants)
___ Performing job responsibilities/ Community activities (work, school…)
___ Performing sports, recreation, play activities
___ Reaching overhead
___ Repetitive Movements of hand, arm, should.
___ Sitting
___ Standing
___ Transfers (getting out of a chair, bed…)
___ Walking
___ Writing/grasping items with hand(s)

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**

ASSOCIATED SURGERY

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 at **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
___Cellulitis
___Circulation/vascular problems
___Communicable Diseases
___Congestive Heart Failure
___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
___Obesity
___Osteoarthritis
___Osteoporosis
___Parkinsons Disease
___Peripheral Neuropathy
___Psychiatric Disorder
___Repeated Infections
___Seizures/Epilepsy
___Spinal Cord Injury
___Skin disease
___Stroke/TIA
___Stomach Problems/Ulcers
___Swallowing Difficulty
___Thyroid Problems
___Vision Impairment
___Other:_____
_____
_____
_____
_____
_____
_____

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
___ Tracheostomy
___Transurethral resection of prostate
___ Other _____

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

___Rods ___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 last page.**

Are you taking any non-prescription medications? (Including herbal supplements/vitamins) **Yes / No** Non-Prescription medications:_____

Are you taking any anticoagulant medications? **Yes / No** Anticoagulant medications: _____

Are you taking any medication for ulcers? **Yes / No** Ulcer medications: _____

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 _____

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?_____

Weight Change

Have you experienced any recent weight change? (Circle one answer) Increase Decrease No Change **# of pounds_____**
Timeframe of weight change _____ Period (Circle one answer) Days Weeks Months Years

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!