Patient Name:_____ DOB:_____

PERSONAL MEDICAL HISTORY

To help us treat you as a whole person instead of just a body part, kindly fill out the information on the following pages. Thank you.

Please check if you have been diagnosed with any of these by a doctor in the past:

[ ] Diabetes / High Blood Sugar
[ ] Hypoglycemia / Low Blood Sugar
[ ] Ulcer / GERD / Stomach Problems
[ ] Rheumatoid Arthritis
[ ] Circulation / Vascular Problems
[ ] Head Injury
[ ] Asthma
[ ] Parkinson's Disease
[ ] Heart Problems
[ ] Cancer
[ ] Depression
[ ] Osteoarthritis
[ ] Lung Problems
[ ] Stroke
[ ] Allergies
[ ] Seizures / Epilepsy
[ ] Anemia
[ ] High Blood Pressure
[ ] Broken Bone / Fracture
[ ] Osteoporosis
[ ] Kidney Problems
[ ] Multiple Sclerosis
[ ] Skin Diseases
[ ] Hepatitis
[ ] Blood Disorder
[ ] Repeated Infections
[ ] Thyroid Problems

Number of falls in the last year: _____

In the last year, have you had any of the following? Please check all that apply:

[ ] Chest Pain
[ ] Shortness of Breath
[ ] Weakness "in.-Arms or Legs
[ ] Joint Pain or swelling
[ ] Difficulty Swallowing
[ ] Urinary Problems
[ ] Headaches
[ ] Heart Palpitations
[ ] Dizziness
[ ] Loss of Balance
[ ] Difficulty Sleeping
[ ] Nausea / Vomiting (not Flu)
[ ] Weight Loss/ Gain
[ ] Hearing Problems
[ ] Cough
[ ] Coordination Problems
[ ] Difficulty Walking
[ ] Loss of Appetite
[ ] Tingling
[ ] Fever / Chills / Sweats
[ ] Vision Problems
[ ] Hoarseness
[ ] Pain at Night
[ ] Numbness
[ ] Bowel Problems
[ ] _____

For <u>MEN</u> only:

Have you ever been diagnosed with prostate disease? [ ] No [ ] Yes
Do you have difficulty beginning to urinate? [ ] No [ ] Yes
Do you have difficulty continuing to urinate? [ ] No [ ] Yes
Do you have pain with urination? [ ] No [ ] Yes

For <u>WOMEN</u> only:

Have you seen a doctor for any pelvic problems? [ ] No [ ] Yes
Are you pregnant or trying? [ ] No [ ] Yes
When was your last Pap Smear:_____ last Breast Exam:_____
Do you ever have any urinary leakage? [ ] No [ ] Yes

Surgery (for <u>ALL</u>):

Have you ever had surgery? [ ] No [ ] Yes _____
if yes, please list approximate date(s): _____

Physical Therapist initials_____

Patient Name:_____ DOB:_____

Are you currently seeing anyone else for the problem that brought you here? Please check all that apply:

[ ] Acupuncturist	[ ] Podiatrist	[ ] Dentist
[ ] Neurologist	[ ] Primary Care Physician	[ ] Cardiologist
[ ] Obstetrician I Gynecologist	[ ] Rheumatologist	[ ] Orthopedist
[ ] Occupational Therapist	[ ] Pediatrician	[ ] Osteopath
[ ] Massage Therapist	[ ] Chiropractor	[ ] _____

Are you allergic to latex? [ ] No [ ] Yes

Are you allergic to oils, lotions, or creams? [ ] No [ ] Yes

Do you smoke or chew tobacco? [ ] No [ ] Yes

if yes, Packs per day: _____ For how long: _____

How many days each week do you drink alcohol? _____

If 1 drink equals 1 beer or 1 glass of wine, how much do you drink in an average sitting?_____

How much caffeinated coffee [or caffeine-containing beverages] do you drink each day?_____

Do you ever feel unsafe at home or has anyone hit you or tried to hit you in any way? [ ] No [ ] Yes

Anything else we should know about?

_____

_____

_____

Medications:

IF YOU HAVE A FULL LIST OF MEDICATIONS, WE CAN COPY IT IF THIS IS EASIER FOR YOU.

Current medications (prescription and over-the-counter) with dosages:

_____

_____

_____

_____

_____

Physical Therapist initials_____

Patient Name:_____ DOB:_____

SOCIAL

With whom do you live? [check ALL that apply]

[ ] Alone
[ ] Spouse / Significant Other Only
[ ] Child
[ ] Spouse / and Other(s)

Does your home have: [check ALL that apply]

[ ] Stairs, no railing
[ ] Uneven Terrain
[ ] Assistive Devices in Bathroom (please list below)
[ ] Obstacles (please list below)
[ ] Stairs, Railing
[ ] Scatter Rugs
[ ] Ramps
[ ] Elevator

_____

_____

Do you use: [check ALL that apply]

[ ] Any Assistive Devices:_____
[ ] Hearing Aids
[ ] Glasses / Contact Lenses
[ ] Other:_____

Do you have difficulty with: [check ALL that apply]

[ ] Moving in Bed
[ ] Walking on Stairs
[ ] Getting Dressed
[ ] Toileting
[ ] Preparing Meals
[ ] Moving from Bed to Chair
[ ] Walking on Ramps/Hills
[ ] Bathing
[ ] Household Chores
[ ] Driving
[ ] Walking on Level Ground
[ ] Walking on Uneven Terrain
[ ] Eating
[ ] Shopping
[ ] Participating in Sports

FAMILY HISTORY: [check ALL that apply]

	Mother	Father	Any Brother/Sister	Any Grandparent
Heart Disease	[ ]	[ ]	[ ]	[ ]
High Blood Pressure	[ ]	[ ]	[ ]	[ ]
Stroke	[ ]	[ ]	[ ]	[ ]
Diabetes	[ ]	[ ]	[ ]	[ ]
Cancer	[ ]	[ ]	[ ]	[ ]
Psychological	[ ]	[ ]	[ ]	[ ]
Osteoporosis	[ ]	[ ]	[ ]	[ ]
Other:_____	[ ]	[ ]	[ ]	[ ]

The above is true to the best of my knowledge

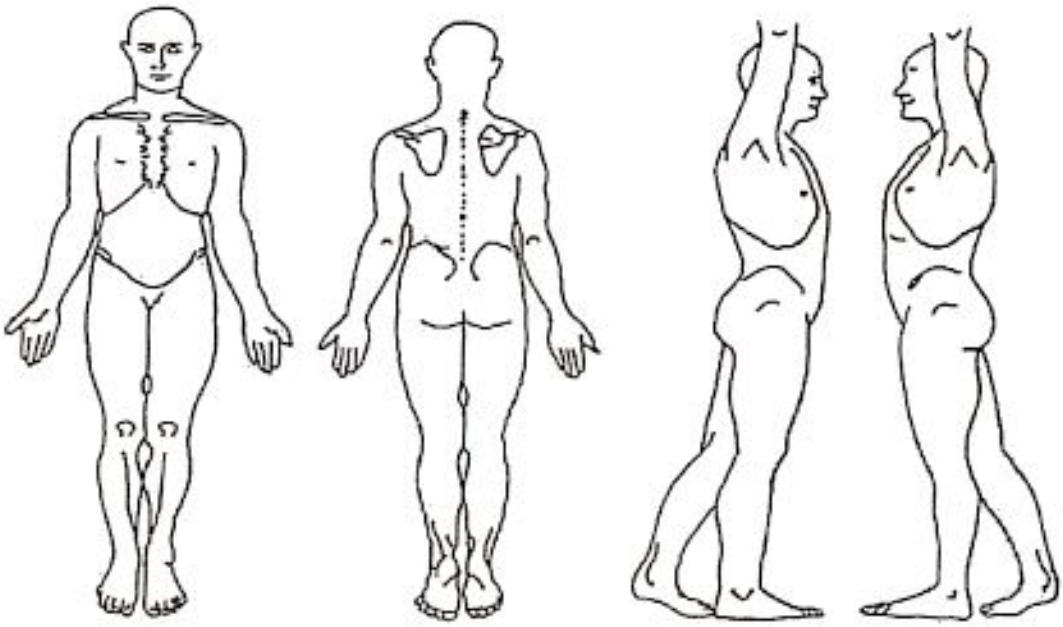
[ ] No [ ] Yes

Physical Therapist initials_____

Patient Name:_____ DOB:_____

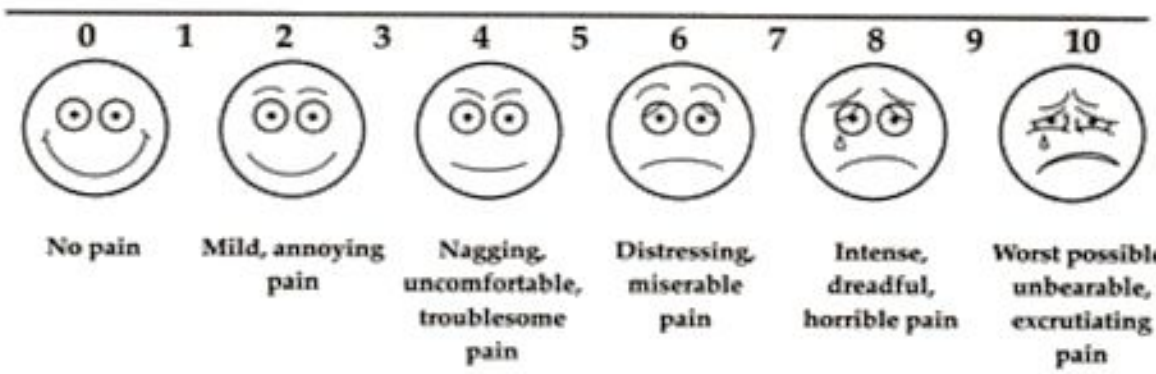
System Questionnaire

Please circle/mark on the below image the location(s) of your pain:



Does your pain come and go? [ ] No [ ] Yes

Using the below scale, please mark letters B, W and A regarding the INTENSITY of your pain:
In the last week, **when you were feeling your BEST (B)**, how low was your pain?
In the last week, **when you were feeling your WORST (W)**, how high was your pain?
What has been your **AVERAGE (A)** pain over the last 24 hours?



Physical Therapist initials_____