DEMOGRAPHICS

Date _____

Name _____

Date of Birth _____

Age _____

Gender _____

Mailing Address _____

Phone Number _____

Email Address _____

Emergency Contact Name _____

Emergency Contact Phone Number _____

How did you hear about Whole Self Wellness? _____

Who referred you to Whole Self Wellness? _____

Occupation and Hobbies _____

Primary Care Physician _____

Physician Phone Number _____

Guardian Name (if patient is under 18) _____

Guardian Phone Number (if patient is under 18) _____

Past Medical History

1. Rate your general health: Poor / Fair / Good

2. List and date any past surgeries: _____
   _____

3. List and date any past hospitalizations: _____
   _____

4. List current medications:_____
   _____

5. Circle the following items you may have experienced or are being treated for:

Allergies	Faint/Dizzy/Vertigo	Unintentional Weight Loss
Anxiety	Gout	Short of Breath/Asthma
Balance/Falls	Fracture	Smoker
High Blood Pressure	Headache	Stroke
Low Blood Pressure	Head Trauma	Swelling/Edema of Limbs
Blood Disease	Heart Attack	Thyroid Disease
Bowel/Bladder Problems	Heart Disease	Tinnitus/Ringing in Ear
Cancer	Hepatitis	Tumor
Car Accident	Hernia	Urinary Incontinence
High Cholesterol	Hearing Difficulties	Vision Trouble
Chronic Constipation	Osteoarthritis	Other Cardiorespiratory
Diarrhea	Osteoporosis	Other Kidney/Urinary
Depression	Currently Pregnant	Other Psychological
Diabetes	Past Pregnancies	Other Reproductive
Difficulty Sleeping	Pelvic Pain	Other Gastrointestinal
Drug Addiction	Radiation Treatment for Cancer	Other Endocrine/Hormonal
Endometriosis		Other Neurological
Epilepsy/Seizure	Rheumatoid Arthritis	

8. Anything else you believe that I should know:
   _____
   _____

I certify that the above information is accurate and complete to the best of my knowledge.

Sign _____ **Date** _____

Parent/Guardian signature if patient is under 18 years old.

Sign _____ **Date** _____

History of Present Illness

1. Symptoms/Condition you are seeking help for today: _____
   _____
2. Is this injury work related? Y / N
3. Is this injury vehicle accident related? Y / N
4. Attorney name _____ Phone_____
5. Case manager name _____ Phone _____
6. Did you have surgery for this condition?
   a. Surgical procedure: _____
   b. Surgical date: _____
   c. Surgeon's name: _____
   d. Next follow up date with surgeon: _____

7. How the symptoms occurred (if known): _____
8. Approximate onset date: _____
9. Have you had the symptoms before?: _____
10. Are the symptoms constant throughout the day?: _____
11. Have you had any diagnostics performed for your symptoms? (xrays, MRI, blood tests, etc):
    _____
12. What types of clinicians/treatments/surgeries have you tried for your symptoms? Did it help?:
    _____
    _____
13. What types of everyday tasks, work, school, or recreational activities are you having trouble doing because of your symptoms?: _____
    _____

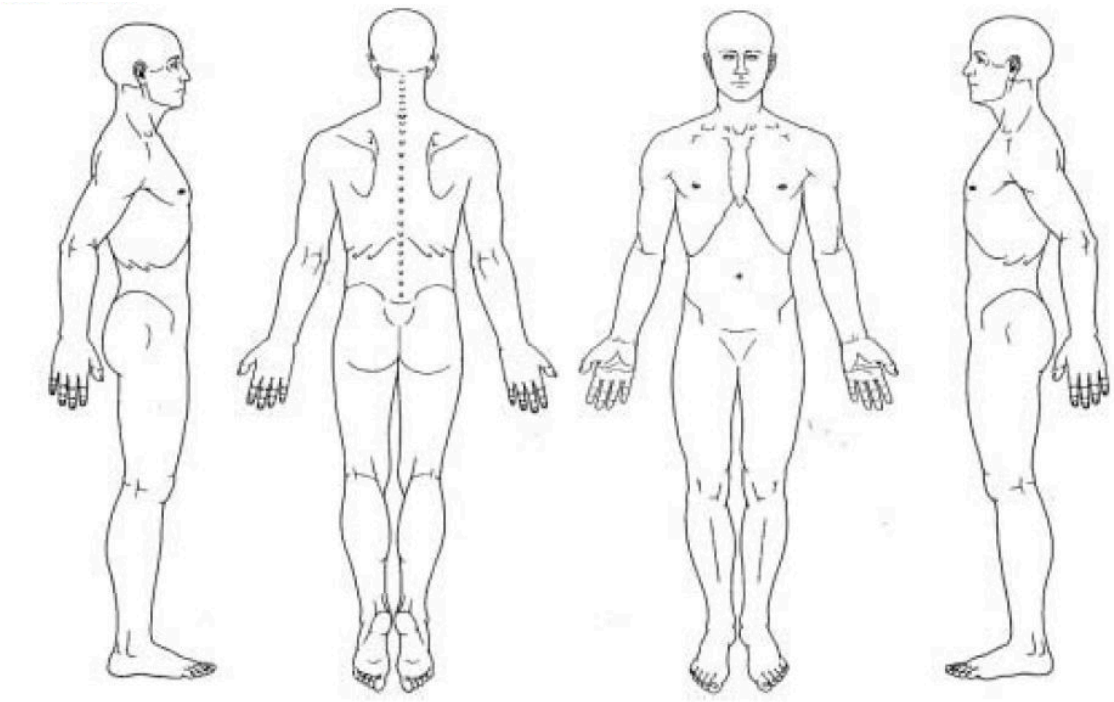
14. On a scale of 0-10 (0 being no symptoms and 10 being unbearable requiring hospitalization)
    a. Rate your symptoms at <u>BEST</u>: _____
    b. Rate your symptoms <u>CURRENTLY</u>: _____
    c. Rate your symptoms at <u>WORST</u>: _____
15. Describe your symptoms: _____
16. What can make your symptoms better?: _____
17. What can make your symptoms worse?:_____

18. What are your goals for physical therapy? _____
    _____
19. Have you had any falls in the past year? _____
20. Do you feel unsteady when standing or walking? _____
21. Do you worry about falling? _____

Symptom Diagram

Using the key provided, please draw the symbol representing your pain over the area of the body as it relates to your present condition.

Key
↑ or ↓ radiating pain
XXX spasm
ZZZ tenderness
/////// numb/tingling
000 ache/pain



I certify that the above information is accurate and complete to the best of my knowledge.

Sign _____ **Date** _____

Parent/Guardian signature if patient is under 18 years old.

Sign _____ **Date** _____

Patient Informed Consent / Consent to Treat

Physical therapy is a patient care service provided in response to a wide range of medical care needs. The purpose of physical therapy is to treat disease, injury, and disability by examination, evaluation, PT diagnosis, prognosis, and intervention. Rehabilitative procedures include mobilization, exercises, and sometimes physical agents to aid the patient in achieving their maximum potential within their capabilities. All procedures will be thoroughly explained to you before they are performed.

You are expected to cooperate fully with the evaluation and treatment program. Because of the nature of services provided, you might be asked to partially disrobe in order to gain access to certain areas of the body. Draping with towels will always be used to limit exposure. Areas of the body that are considered private such as the chest, abdomen, pelvic region, and buttock, along with all other parts of the body, may also be assessed and treated which often will require manual contact by your therapist. If this is necessary, your privacy, modesty, and dignity will always be considered by the therapist and the utmost professionalism will be demonstrated. Should you feel uncomfortable you may refuse or stop the procedure and/or request to have a chaperone present.

There are certain inherent risks with physical therapy treatments. You will be asked to exert effort and perform activities with increasing degree of difficulty that could cause an increase in your current level of pain, discomfort, or an aggravation to your existing injury. You will be able to stop treatment if you feel any discomfort or pain. Your physical therapist will take every precaution to ensure that you are protected from any potentially hazardous situation. You will never be forced to perform any procedure that you do not wish to perform.

I agree to the terms of the Patient Informed Consent Policy and I consent to evaluation and treatment by physical therapy providers.

Sign _____ **Date** _____

Parent/Guardian signature if patient is under 18 years old.

Sign _____ **Date** _____