

To insure you receive a complete and thorough evaluation, please provide us with important background information on the following form. If you do not understand the question, your therapist will assist you. Thank you.

Name: _____

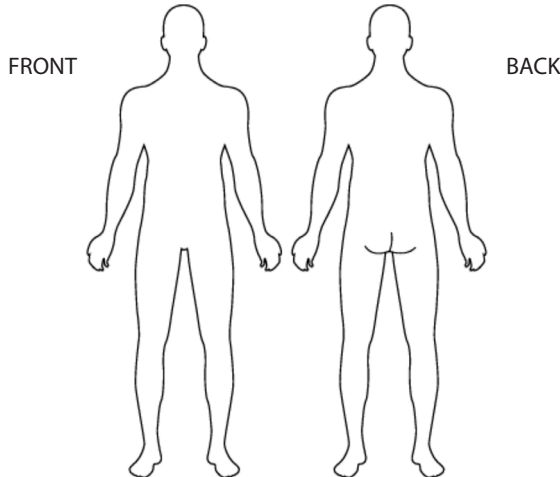
Date: _____ Age: _____

Weight: _____ Height: _____

HISTORY OF PRESENT CONDITION

1. What are your symptoms? _____

Localize areas of **pain** or **abnormal** sensation on the body chart below (Shade in where appropriate)



2. When did your symptoms begin?
 (Please indicate a specific date if possible) _____

On a scale from 1-10 please indicate your level of pain?
 (0 being "no pain" and 10 being "worst pain imaginable") _____

3. Was the **onset** of this episode gradual or sudden? (check one)
 gradual sudden

4. Which of the following **best describes** how your injury occurred?
 (if your condition is post-surgical please indicate as per original injury)

- | | |
|--|---|
| <input type="checkbox"/> lifting | <input type="checkbox"/> a blow to the face |
| <input type="checkbox"/> a MVA (car accident) | <input type="checkbox"/> being hit by a ball |
| <input type="checkbox"/> a fall | <input type="checkbox"/> a dental appointment |
| <input type="checkbox"/> overuse (cumulative trauma) | <input type="checkbox"/> throwing |
| <input type="checkbox"/> trauma | <input type="checkbox"/> an incident at work |
| <input type="checkbox"/> degenerative process | <input type="checkbox"/> unknown |
| <input type="checkbox"/> during recreation/sports | <input type="checkbox"/> other _____ |
| <input type="checkbox"/> running | |

5. Since onset, are your symptoms getting: (check one)
 better worse not changing

6. Have you had similar symptoms in the past?
 Yes No
 More than one episode?
 Yes No

7. Nature of pain/symptoms (check all that apply)
 sharp aching constant
 dull periodic other _____
 throbbing occasional _____

8. As the day progresses, so your symptoms: (check one)
 increase decrease stay the same

9. Does the pain wake you at night? No Yes
 if "yes", is it present while lying still
 only when changing positions
 both

10. Do you have pain/stiffness upon getting out of bed in the morning?
 Yes No

11. In what position do you sleep? (check all that apply)
 right side back other
 left side chair/recliner
 stomach back, sides, stomach

12. Since the onset of your current symptoms have you had:
 any difficulty with control of bowel or bladder function
 fever/chills
 any numbness in the genital or anal area
 numbness
 any dizziness or fainting attacks
 weakness
 unexplained weight change
 night pain/sweats
 malaise (vague feeling of bodily discomfort)
 problems with vision/hearing
 none of the above

13. What aggravates your symptoms? (check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> sitting | <input type="checkbox"/> repetitive activities |
| <input type="checkbox"/> going to/rising from sitting | <input type="checkbox"/> lying down |
| <input type="checkbox"/> household activities | <input type="checkbox"/> walking |
| <input type="checkbox"/> up/down stairs | <input type="checkbox"/> standing |
| <input type="checkbox"/> reaching overhead | <input type="checkbox"/> squatting |
| <input type="checkbox"/> reaching in front of body | <input type="checkbox"/> sleeping |
| <input type="checkbox"/> reaching behind back | <input type="checkbox"/> coughing/sneezing |
| <input type="checkbox"/> reaching across body | <input type="checkbox"/> taking a deep breath |
| <input type="checkbox"/> talking, chewing, yawning, all (circle one) | <input type="checkbox"/> looking up overhead |
| <input type="checkbox"/> recreation/sports including _____ | <input type="checkbox"/> swallowing |
| | <input type="checkbox"/> stress |
| | <input type="checkbox"/> sustained bending |
| | <input type="checkbox"/> other _____ |

14. What relieves your symptoms? (check all that apply)

- | | | |
|--|-------------------------------------|--------------------------------------|
| <input type="checkbox"/> sitting | <input type="checkbox"/> rest | <input type="checkbox"/> massage |
| <input type="checkbox"/> heat | <input type="checkbox"/> standing | <input type="checkbox"/> medication |
| <input type="checkbox"/> cold | <input type="checkbox"/> walking | <input type="checkbox"/> nothing |
| <input type="checkbox"/> stretching | <input type="checkbox"/> exercise | <input type="checkbox"/> other _____ |
| <input type="checkbox"/> wearing a splint/orthosis | <input type="checkbox"/> lying down | _____ |

15. Have you had any previous treatment for this condition?
 (check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> none | <input type="checkbox"/> physical therapy |
| <input type="checkbox"/> medication (oral) | <input type="checkbox"/> hypnosis |
| <input type="checkbox"/> joint manipulation | <input type="checkbox"/> biofeedback |
| <input type="checkbox"/> exercise | <input type="checkbox"/> TENS unit |
| <input type="checkbox"/> massage therapy | <input type="checkbox"/> acupuncture |
| <input type="checkbox"/> traction | <input type="checkbox"/> bed rest |
| <input type="checkbox"/> bracing/taping | <input type="checkbox"/> overnight hospitalization |
| <input type="checkbox"/> injection into spine | <input type="checkbox"/> casting |
| <input type="checkbox"/> injection into skin/muscles | <input type="checkbox"/> other _____ |

16. Have you had any of the following tests?

- | | | |
|----------------------------------|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> none | <input type="checkbox"/> Arthrogram | <input type="checkbox"/> TENS unit |
| <input type="checkbox"/> x-rays | <input type="checkbox"/> biofeedback | <input type="checkbox"/> Vestibular |
| <input type="checkbox"/> CT Scan | <input type="checkbox"/> Bone Scan | <input type="checkbox"/> other _____ |
| <input type="checkbox"/> MRI | <input type="checkbox"/> Stress x-ray | _____ |

Test Results: _____

MEDICATION

Please list any prescription medications you are currently taking
(pain pills, injections and/or skin patches, etc.):

Prescribing MD: _____ Phone: _____

Are you currently taking any of the following over the counter medications?

- | | |
|--|---|
| <input type="checkbox"/> aspirin | <input type="checkbox"/> vitamins/mineral supplements |
| <input type="checkbox"/> Tylenol | <input type="checkbox"/> Advil/Motrin/ibuprofen |
| <input type="checkbox"/> corticosteroids | <input type="checkbox"/> other _____ |
| <input type="checkbox"/> antihistamines | |

PREVIOUS FUNCTIONAL LEVEL

- Independent in all activities
(work, community, home, recreation)

Self-care

- Independent in all self-care activities
(bathing, toileting, dressing, etc.)
- Difficulty performing self-care activities
- Need assistance with self-care activities
- Difficulty performing household chores

Social

- Need assistance with activities in community outside of home

Hobbies: _____

CURRENT FUNCTIONAL LEVEL

- Independent in all activities
(work, community, home, recreation)

Self-care

- Independent in all self-care activities
(bathing, toileting, dressing, etc.)
- Difficulty performing self-care activities
- Need assistance with self-care activities
- Difficulty performing household chores

Social

- Need assistance with activities in community outside of home

Hobbies: _____

WORK HISTORY

Occupation

- | | |
|---|--------------------------------------|
| <input type="checkbox"/> employed full-time | <input type="checkbox"/> student |
| <input type="checkbox"/> employed part-time | <input type="checkbox"/> retired |
| <input type="checkbox"/> self employed | <input type="checkbox"/> unemployed |
| <input type="checkbox"/> homemaker | <input type="checkbox"/> other _____ |

Physical activities at work (check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> sitting | <input type="checkbox"/> computer use |
| <input type="checkbox"/> standing | <input type="checkbox"/> heavy equip. operation |
| <input type="checkbox"/> phone use | <input type="checkbox"/> driving |
| <input type="checkbox"/> repetitive lifting | <input type="checkbox"/> other _____ |
| <input type="checkbox"/> heavy lifting | |

Are you currently receiving or seeking disability for this condition?

- Yes No

If not performing your normal activities at work do you plan to RETURN to your previous activity level?

- Yes No

LIVING SITUATION

- | | |
|---|--|
| <input type="checkbox"/> live alone | <input type="checkbox"/> home/apartment |
| <input type="checkbox"/> live with family members | <input type="checkbox"/> assisted living complex |
| <input type="checkbox"/> live with caregiver | <input type="checkbox"/> other _____ |
| <input type="checkbox"/> retirement complex | |

Setting:

- | | | |
|--|------------------------------------|--|
| <input type="checkbox"/> stairs (railing) | <input type="checkbox"/> no stairs | <input type="checkbox"/> uneven ground |
| <input type="checkbox"/> stairs (no railing) | <input type="checkbox"/> ramp | <input type="checkbox"/> elevator |
| <input type="checkbox"/> other _____ | | |

GENERAL HEALTH

How would you rate your average health?

- | | | |
|------------------------------------|----------------------------------|-------------------------------|
| <input type="checkbox"/> Excellent | <input type="checkbox"/> Average | <input type="checkbox"/> Poor |
| <input type="checkbox"/> Good | <input type="checkbox"/> Fair | |

Do you use exercise outside of normal daily activities?

- | | | |
|--------------------------------------|---------------------------------------|-------------------------------|
| <input type="checkbox"/> 5+ days/wk | <input type="checkbox"/> 1-2 days/wk | <input type="checkbox"/> zero |
| <input type="checkbox"/> 3-4 days/wk | <input type="checkbox"/> occasionally | |

Recreation activities consisting of:

- | | | |
|-----------------------------------|--------------------------------------|----------------------------------|
| <input type="checkbox"/> running | <input type="checkbox"/> golfing | <input type="checkbox"/> walking |
| <input type="checkbox"/> biking | <input type="checkbox"/> tennis | <input type="checkbox"/> skiing |
| <input type="checkbox"/> swimming | <input type="checkbox"/> other _____ | |

Do you drink caffeinated beverages?

- No Yes How many/much per day _____

Do you smoke?

- No Yes Packs of cigarettes per day _____

What is your stress level?

- Low Medium High

Are you seeing any health care providers other than the physical therapist for this current condition? (please list)

PAST MEDICAL HISTORY

Have you ever had/been diagnosed with any of the following condition? (check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> Cancer (type) _____ | <input type="checkbox"/> Heart problems |
| <input type="checkbox"/> Depression | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Lung problems |
| <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Blood disorders |
| <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Epilepsy/seizures |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Rheumatoid arthritis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Head injury | <input type="checkbox"/> Broken bone |
| <input type="checkbox"/> Stomach problems | <input type="checkbox"/> Circulation/vascular problems |
| <input type="checkbox"/> Parkinson's disease | <input type="checkbox"/> other _____ |
| <input type="checkbox"/> Infectious disease
(i.e. Hepatitis, Tuberculosis, etc.) | |

Please list any past surgeries related to you current problem:

SURGERY	DATE
_____	_____
_____	_____

FAMILY HISTORY

Has anyone in your immediate family (parents, brothers, sisters) ever been treated for the following?

- | | |
|--|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Psychological condition |
| <input type="checkbox"/> Other _____ | |