

Client Demographic Information

Today's Date: _____

Name: _____

Date of Birth: _____

Phone Number: _____

Emergency Contact(Name and Phone): _____

Address: _____

Email: _____

How did you hear about us? Doctor Friend Internet Other _____

How would you like to receive reminders about your appointment? Text Phone call Email

Occupation: _____

Work status? _____

Dominant hand Right Left Ambidextrous

Have you fallen in the last year? Yes No If yes, were you injured? Yes No Describe _____

How much physical activity or exercise per week? 30+ minutes 5+days/wk 30+min 3-5 days/wk

30+min 1-3 days/wk less than 30 minutes 1-3 days/wk not regularly exercising Other _____

Are you interested in learning about how a medically based fitness program can safely optimize your health?
 Yes No

What daily activities are you having difficulty performing? _____

What are your goals for physical therapy? _____

Do you have difficulty hearing? Yes No Do you have hearing aids? Yes No

Symptom Questionnaire

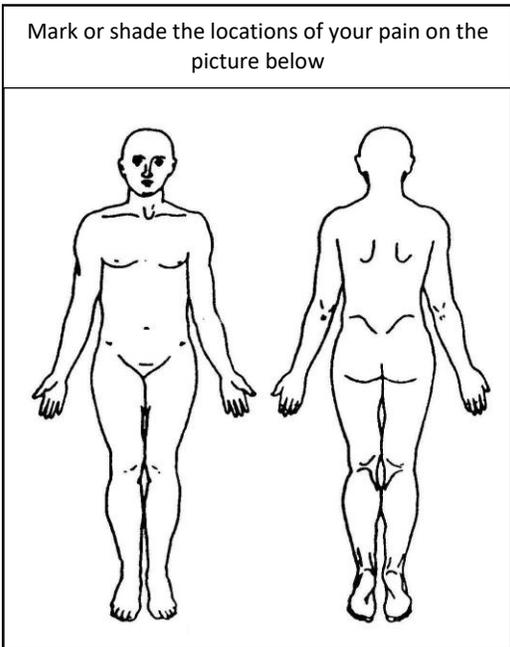
What problem or issue brings you here? _____

How and when did it start? _____

Did you have surgery? Yes No Procedure: _____ Date of surgery? _____

What tests have you had? X-ray MRI CT scan EMG Bone scan Other _____

What treatments have you had? Physical Therapy Massage Chiropractic Other _____



Please describe your pain or chief symptoms: (check all that apply) **Please describe the intensity and pattern of symptoms:**

- Vertigo, room spinning
- Light headedness
- Imbalance
- Ear pressure/pain
- Motion intolerance
- Headaches/migraine
- Head injury/concussion
- Tingling
- Burning
- Shooting
- Throbbing
- Dull pain / ache
- Sharp pain

Symptoms are...

- Getting better
- Not changing
- Getting worse

Symptoms are worse...

- Morning
- Afternoon
- Night
- Constant

Activities/positions that increase symptoms _____

Activities/positions that decrease symptoms _____

Place marks on lines to indicate your level of pain/ symptoms
 0= no pain/symptoms 5= symptoms cause you to stop activities 10= must go to hospital
 Please rate your **CURRENT** level of pain or symptoms on the line below

0 1 2 3 4 5 6 7 8 9 10
 Please rate your **BEST** level of pain or symptoms on the line below

0 1 2 3 4 5 6 7 8 9 10
 Please rate your **WORST** level of pain or symptoms on the line below

0 1 2 3 4 5 6 7 8 9 10

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Do you have a pacemaker? Yes No Do you have high blood pressure? Yes No What is usual BP? _____
 Do you have any joint replacements or metal implants? Yes No Please list types and dates: _____

Do you have a history of cancer or tumors? Yes No Please describe type and date: _____
 Chemotherapy ? Yes No Radiation ? Yes No

Recent night pain or fevers/ sweats	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vision change or double vision	<input type="checkbox"/> Yes <input type="checkbox"/> No
Unintentional weight change	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of breath?	<input type="checkbox"/> Yes <input type="checkbox"/> No
New rashes / psoriasis?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sleep problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Depressed mood?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Anxiety?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Joint swelling?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nausea, vomiting, bowel or bladder changes?	<input type="checkbox"/> Yes <input type="checkbox"/> No

History of tobacco use? Never Yes Quit Current Cigarette packs/day _____ Cigar Pipe Chew
 Number of caffeinated drinks per day? _____ Alcohol use? Yes No if Yes, drinks per week? _____
 Do you leak urine, even a small amount? Yes No Do you have to rush to use the bathroom? Yes No

WOMEN: Currently pregnant? Yes No Est. date of delivery _____ Number of pregnancies? _____

Medical History and Family History. If you have ever had a listed condition in the past, please check it in the PAST column. If you are presently troubled by a particular condition, check it in the PRESENT column. If you have a family history of a condition, check it in the FAMILY column. The information you provide concerning past and present conditions and diseases assists your doctor in more thoroughly understanding your state of health.

CONDITION	PAST	PRESENT	FAMILY	CONDITION	PAST	PRESENT	FAMILY
Angina	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Systemic Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke/TIA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Peripheral neuropathy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood clot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma / Respiratory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Infectious diseases	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy / seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lower limb edema/swelling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other Present or Past Medical Conditions: _____

Medications- For additional room provide a list medications

Name	Reason for taking	Dosage
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Hospitalization/Surgical Procedures (not described elsewhere): Additional surgeries provide a list please

Type	Date
_____	_____
_____	_____
_____	_____
_____	_____

Client Signature _____ Date _____