Clinical Information Form

FYZICAL Therapy & Balance Centers

Patient Name_____ *(Please Print)* Date ____/____/____

Date of Birth: ____/____/____ Gender: ☐ Male ☐ Female

Occupation _____ ☐ Employed (full) ☐ Employed (restricted) ☐ Disability ☐ Retired ☐ Student ☐ Unemployed

Describe your symptoms_____

When did your symptoms first start? _____

How often do you experience your symptoms?
Constantly (75-100% of the day)
Frequently (50-75% of the day)
Intermittently (25-50% of the day)
Occasionally (0-25% of the day)

What words best describe your symptoms?
Sharp, Throbbing, Tingling, Shooting, Ache, Dull, Burning, Numb, Tight

Please rate your pain at its worst → (No pain) 0 1 2 3 4 5 6 7 8 9 10 (Severe pain)

Please rate your pain currently → (No pain) 0 1 2 3 4 5 6 7 8 9 10 (Severe pain)

Please rate your pain at its best → (No pain) 0 1 2 3 4 5 6 7 8 9 10 (Severe pain)

List any positions or activities that **increase** your symptoms _____

List any positions or activities that **decrease** your symptoms _____

Did you have any falls over the past year?
Yes No *If yes, how many?* ____

Did you have an injury as a result of the fall?
Yes No

Please check any of the following problems that apply to you:

- ☐ No known significant PMH to affect treatment
- ☐ Alzheimer's
- ☐ Cardiovascular Disease
- ☐ Cauda Equina Syndrome
- ☐ Cerebral Vascular Accident
- ☐ Current Infection
- ☐ Diabetes Mellitus Type I
- ☐ Diabetes Mellitus Type II
- ☐ Fibromyalgia
- ☐ Fracture or Suspected Fracture
- ☐ High Blood Pressure
- ☐ History of Cancer
- ☐ Immunosuppression
- ☐ Lupus
- ☐ Muscular Dystrophy
- ☐ Obesity
- ☐ Osteoarthritis
- ☐ Parkinson's
- ☐ Rheumatoid Arthritis
- ☐ Traumatic Brain Injury
- ☐ Osteoporosis
- ☐ Asthma
- ☐ Lung Disease
- ☐ Gastrointestinal Disease (Ulcer, Hernia, Reflux, Bowel, Liver, Gall Bladder)
- ☐ Visual Impairments (Cataracts, Glaucoma, Macular Degeneration
- ☐ Hearing Impairment
- ☐ Back Pain
- ☐ Previous Accidents
- ☐ Incontinence
- ☐ Anxiety, Panic Disorders, or Depression
- ☐ Prior Surgery
- ☐ Prosthesis/Implants
- ☐ Sleep Dysfunction
- ☐ Tobacco Use
- ☐ Other_____

Height: _____Feet _____Inches Weight: _____lbs.

Do you have a pacemaker or defibrillator? ☐ Yes ☐ No

Patient Goals_____