Reason for Therapy

When did the condition begin?* - -

Is this a work related injury? ○ Yes ○ No

Date of next doctor appointment for this condition

Describe the onset and history of current condition(s)*

Current Symptoms

Rate Symptom Intensity in the Past 5 Days

Symptoms at Worst Symptoms at Best

(0 is no pain or symptoms and 10 is the worst possible pain or symptoms)

Surgery

Did you have surgery for this condition? ○ Yes ○ No Date of Surgery (if applicable)

Type of Surgery (if applicable)

How do activities change the symptoms?

Please list the activities that make your symptoms worse

Please list the activities that make your symptoms better

What activities can you no longer do due to this condition?

Diagnostic Tests

Please list any diagnostics tests you have received for this condition and the results if known

Medical Conditions

Do you have any medical condition you currently suffer from or have experienced in the past?* ○ Yes ○ No

List of Medical Conditions

Please indicate any medical conditions you currenlty suffer from or have experienced in the past

- ☐ Abnormal Bleeding
- ☐ Angina
- ☐ Anxiety
- ☐ Arrhythmia
- ☐ Asthma
- ☐ Bipolar Disorder
- ☐ Blood Clotting Disorder
- ☐ Bowel Incontinence
- ☐ Cancer
- ☐ Carpal Tunnel Syndrome
- ☐ Cellulitis
- ☐ Chronic Back Pain
- ☐ Chronic Neck Pain
- ☐ Closed Head Injury
- ☐ Colitis
- ☐ Congestive Heart Failure
- ☐ COPD
- ☐ Crohn's Disease
- ☐ CVA (Stroke)
- ☐ Degenerative Disc Disease
- ☐ Depression
- ☐ Diabetes Type I
- ☐ Diabetes Type II
- ☐ DVT
- ☐ Fibromyalgia
- ☐ Frequent UTI
- ☐ GERD
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Hiatal Hernia
- ☐ High Cholesterol
- ☐ HIV/AIDS
- ☐ Hypertension
- ☐ Hypothyroidism
- ☐ Irritable Bowel Syndrome
- ☐ Joint pain
- ☐ Lymphedema
- ☐ Migraine Headaches
- ☐ MRSA
- ☐ Multiple Sclerosis
- ☐ Myocardial Infarction
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Psoriatic Arthritis
- ☐ PVD
- ☐ Rheumatoid Arthritis
- ☐ Scoliosis
- ☐ Seizure Disorder
- ☐ Shortness of Breath
- ☐ Sleeping Disorder
- ☐ TB
- ☐ Urinary Incontinence

Other Conditions

Do you have a pacemaker ○ Yes ○ No

List any additional conditions not already included

Surgeries

Have you had any surgeries?* ○ Yes ○ No

List surgeries you have had, including date if known

Medication

Do you take any medications or over the counter supplements?* ○ Yes ○ No

Medications, Vitamins and Supplements

Name	Dose	Frequency	Method

+

Allergies

Do you have any allergies to medication, food or other substances we need to be aware of?* ○ Yes ○ No

Please provide details

Who do you live with?

Select all that apply*

- [ ] Spouse
- [ ] Parent(s)
- [ ] Other Family Members
- [ ] Child(ren)
- [ ] Alone
- [ ] Other

Is assistance provided by others who do not live in the home? ○ Yes ○ No

Type of home

- ○ Single Level Home
- ○ 2 Level Home
- ○ Ground Floor Apartment
- ○ Upper Level Apartment
- ○ Assisted Living Facility
- ○ Skilled Nursing Facility
- ○ Other

Stairs

Are there stairs to get into the home? ○ Yes ○ No How Many? Handrail?

Are there stairs inside the home? ○ Yes ○ No How Many? Handrail?

Is there a Ramp to get into the home? ○ Yes ○ No

Where is the bathroom located? Where is the bedroom located?

Disability History

Are you permanently disabled? ○ Yes ○ No Please describe disabilities

Year of Disability

Smoking

Do you currently smoke?* ○ Frequently ○ Occasionally ○ Rarely ◉ Never

If yes, how many packs per day?

Have you smoked in the past?

How many years did you smoke for?

How many packs per day?

How many years ago did you quit smoking?

Alcohol

Do you drink alcohol?* ○ Frequently ○ Occasionally ○ Rarely ○ Never

How many times per week?

How many drinks each time?

Street Drugs

Do you use illicit drugs?* ○ Frequently ○ Occasionally ○ Rarely ○ Never

Type

- [ ] Cocaine
- [ ] Heroin
- [ ] Pain medications
- [ ] Ecstasy
- [ ] Marijuana
- [ ] Other prescription medications

Additional Information

Work Status

What is your current work status?*

What is your Occupation?

What is your current ablity to work?

Do you have any restrictions on your job duties currently due to your current conditions? ○ Yes ○ No

Please provide details

Normal Work Duties

Currently able to perform?

Sitting for extended periods	○ Yes	○ No	○ N/A
Standing for extended periods	○ Yes	○ No	○ N/A
Repetitive bending	○ Yes	○ No	○ N/A
Repetitive lifting	○ Yes	○ No	○ N/A
Lifting moderate weights	○ Yes	○ No	○ N/A
Lifting heavy weights	○ Yes	○ No	○ N/A
Operating heavy equipment	○ Yes	○ No	○ N/A
Driving	○ Yes	○ No	○ N/A
Typing/computer operation	○ Yes	○ No	○ N/A
Walking	○ Yes	○ No	○ N/A

Equipment

Do you use any equipment to assist with mobility or daily activities?* ○ Yes ○ No

Please indicate any equipment that is used by the patient

☐ Cane	☐ Power Wheelchair	☐ Dressing Aid	☐ Hoyer Lift	☐ Hand Splint(s)
☐ Walker	☐ Scooter	☐ Special Utensils	☐ Stair Lift	☐ Braces
☐ 2-wheeled walker	☐ Slide Board/Transfer Aid	☐ Reacher	☐ Track System	☐ TENS Unit
☐ 4-wheeled walker	☐ Raised Toilet Seat	☐ Power-Lift Recliner	☐ Stander	☐ Oxygen
☐ Manual Wheelchair	☐ Bath/Shower Chair	☐ Hospital Bed		

Feeding

Do you have any concerns relating to feeding?* ○ Yes ○ No

Current feeding adaptations

Do you use any of the following feeding adaptations? Please provide details if possible

☐ Thickened liquids	Please specify			
☐ Adapted utensils	Details			
☐ Adapted seating	Details			
☐ Calorie Supplements	Details			
☐ Tube Feeding	Amount		Times per day	

Please provide some details of these concerns

Memory

Do you have any concerns about your memory?* ○ Yes ○ No

Please provide some details of these concerns

Speech

Do you have any concerns about your speech or ability to communicate with others?* ○ Yes ○ No

Please provide some details of these concerns

***Any additional information not requested above you would like your therapist to know.**

Additional Information