Koon

Physical Therapy

Initial History Information

Date:_____ Cellular Telephone Number: _____

Name:_____ Home Telephone Number:_____

Home Address: _____

Email Address: _____

Are you currently working? Yes No Retired Occupation:_____

If yes, how many hours do you work a week?_____ Work Telephone Number:_____

Work Address:_____

Gender (*circle*): Male Female Height:_____ Weight: _____ lbs.

Date of Birth:_____ Age:_____ Dominant Hand: Right Left

Referring Physician _____ Primary Physician _____

Do you have a follow up appointment with your doctor? Yes No If yes, when?_____

How did you hear about us? (*circle*) Doctor Insurance Friend/Relative Other_____

To all female patients: Are you pregnant? Yes No If yes, how many weeks?_____

Date of **Injury**:_____ Date of **Surgery**:_____

Please list your current **complaints** or **problems:**

1)_____ 3)_____
2)_____ 4)_____

How did this problem start (*circle*): Slow Sudden Don't know

Briefly describe how the problem started:_____
_____
_____

Have you ever had this problem before? Yes No If yes, how long ago?_____
Did you have a full recovery? Yes No

Please indicate below if you have had any of the following tests (for this current problem): ( ) None

( ) X-Ray Date: _____ Results: _____
( ) CT Scan Date: _____ Results: _____
( ) MRI Date: _____ Results: _____
( ) Other _____ Date: _____ Results: _____

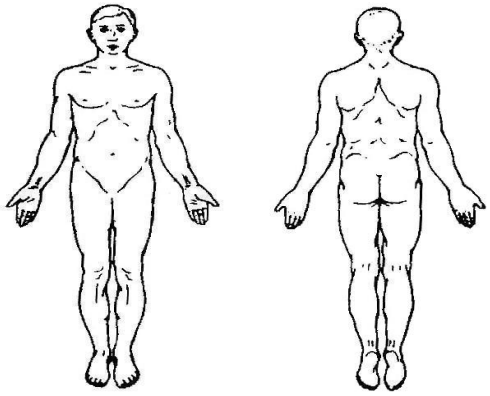
Please describe your pain:

Is your pain (*circle*): Always There Comes and Goes Don't Know

Since this problem started, it is (*circle*): Better No Change Worse

Describe your pain (*circle*): Ache/Sore Sharp Dull Throbbing Tingling Hurt Stabbing
Burning Shooting Pulling Itching Pinching Stinging Rawness
Mild Medium Severe Other:_____

Please indicate on this body map where you are having your problem(s)
(can mark with an X or circle the area)



How much pain are you having today? (*circle*):

No Pain **Take me to the Hospital**

0 1 2 3 4 5 6 7 8 9 10

How much pain did you have last week? (*circle*):

0 1 2 3 4 5 6 7 8 9 10

Do you have any numbness or loss of sensation? Yes No If yes, where?_____

Since this problem began, are you having trouble controlling your bowel or bladder function? Yes No

Please rate your function (*circle*):

Can do nothing **Can do everything I need to do**

0 1 2 3 4 5 6 7 8 9 10

Please rate how much this problem is effecting the quality of your life (*circle*):

No effect **Worst effect**

0 1 2 3 4 5 6 7 8 9 10

Are your symptoms worst in AM or PM:_____

Have you had any other surgeries? Yes No If yes, describe (including date or year): _____

_____

_____

Circle what seems to make your problem worse or <u>difficult</u>: Bending Lifting Carrying Groceries

Reaching Sitting (time_____ min) Stairs Squatting Running/Jogging Walking Everything

Exercising Sleeping Standing (time_____ min) Lying Down (time_____ min)

Brushing hair/teeth Reaching behind back Taking Deep Breath Tying Shoes Getting Dressed

Other :_____

Circle what seems to make your problem **better**: Resting Sitting Standing Lying down

Movement Exercise Heat Ice Taking medication Massage Walking Stretching Nothing

Other : _____

Are you experiencing any of the following? ( ) None

( ) Sudden loss of weight
( ) Fever
( ) Shortness of Breath
( ) Bloody Urination
( ) Dizzy or Fainting Spells
( ) Chest Pain
( ) Persistent Cough
( ) Pain when you cough or sneeze

Please indicate if you have been **diagnosed** with any of these medical problems: ( )No Medical Problems

( ) Anemia
( ) Anxiety
( ) Arthritis
( ) Asthma (adult/child)
( ) Cancer
( ) Cataracts
( ) Chest Pain
( ) Childhood Arthritis
( ) Depression
( ) Diabetes (Type I, Type II)
( ) Glaucoma
( ) Head Injury
( ) Heart Attack
( ) Heart Murmur
( ) Hepatitis (A,B,C)
( ) High Blood Pressure
( ) High Cholesterol
( ) Irregular Heartbeat
( ) Kidney Problems
( ) Migraines
( ) Osteoporosis
( ) Rheumatoid Arthritis
( ) Rheumatic Fever
( ) Seizure Disorder
( ) Stroke
( ) Tuberculosis
( ) Thyroid Disease

Do you take vitamins or herbal supplements? Yes No If yes, what do you take_____
_____

Do you take any medications (either prescription or over the counter)? Yes No

List any medications you are taking (**the receptionist can make a copy of your list of medications**):

_____ _____ _____
_____ _____ _____
_____ _____ _____

Do you have any **allergies** to medicine? Yes No If yes, list the medications here**:** _____
_____

Are you allergic or sensitive to latex? Yes No

Do you exercise? Yes No If yes, describe (including how often)_____

Do you Currently smoke? Yes No If yes, how much (packs per day)_____

Have you ever Smoked? Yes No If yes, When and how much._____

Do you drink alcohol? Yes No If yes, how often _____

Caffeine? Yes No If yes, what & how much _____

How much water do you consume daily? _____

Home environment: Do you live alone? Yes No If no, who is with you?_____

Do you have stairs at home? Yes No If yes, how many?_____

What do you want to achieve and learn as a result of therapy? Please List

_____
_____
_____

_____ _____ _____ _____
(**Patient Signature / Date**) (**Therapist Signature / Date**)