Dr. Physio
THERAPY & WELLNESS

LOCATIONS
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CONTACT US
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MEDICAL HISTORY / BACKGROUND INFORMATION

To ensure you receive a complete and thorough evaluation, please provide us with the important background information on the following form. If you don't understand a question, leave the area blank and your therapist will assist you. Thank you!

PATIENT'S NAME:_____ DOB:_____ /_____ /_____
What is your primary reason for today's appointment? _____
What is your main personal goal(s) with therapy? _____
Please briefly describe your symptoms: _____
_____
What do you think caused your symptoms? _____
Onset Date (roughly): _____ Duration:_____
Have you done any special tests performed for this problem (X-ray, MRI, labs etc)? YES____ NO_____
Have you ever seen another therapist for this problem? YES____ NO_____
Are you CURRENTLY seeing any of the following?

- ☐ Physician
- ☐ Nurse
- ☐ Physical / Occupational
- ☐ Speech Therapist
- ☐ Psychiatrist/Psychologist
- ☐ Chiropractor

If you have seen any of the above during the past three months, please describe for what reason (illness, medical condition, physical, etc.): _____

Have you <u>RECENTLY</u> noted any problems or difficulties with the following (*check all that apply*)?

- ☐ Changes in Bowel movements
- ☐ Constipation/Diarrhea
- ☐ Rectal bleeding
- ☐ Changes in Bladder Function
- ☐ Swallowing Difficulty
- ☐ Nausea/Vomiting
- ☐ Fatigue
- ☐ Numbness/Tingling
- ☐ Fever/Chills/Sweats
- ☐ Persistent Cough
- ☐ Shortness of Breath
- ☐ Wheezing
- ☐ Weight Loss/Gain
- ☐ Fainting
- ☐ Indigestion/Heartburn
- ☐ Abdominal Pain
- ☐ Recent Falls
- ☐ Headaches / Migraines
- ☐ Hearing Changes
- ☐ Vertigo
- ☐ Dizziness / Lightheadedness
- ☐ Swelling in Extremities
- ☐ Painful Urination
- ☐ Painful Intercourse
- ☐ Imbalance While Walking
- ☐ Recent Muscle Weakness
- ☐ Difficulty Focusing on Things
- ☐ Edema in Lower Extremities
- ☐ Concussions: Head or Ear
- ☐ Unconsciousness Episode

Have you <u>EVER</u> been diagnosed and/or having any of the following conditions *(check all that apply)*?

- ☐ Heart problems
- ☐ Chest pain / Angina
- ☐ Pacemaker
- ☐ Circulation Problems
- ☐ Urinary Tract Infection
- ☐ Kidney Problem / Infection
- ☐ Eye Problem / Infection
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Asthma
- ☐ Emphysema / Bronchitis
- ☐ Lung Disease
- ☐ Pneumonia
- ☐ Anemia
- ☐ Rheumatoid Arthritis
- ☐ Osteoarthritis
- ☐ Bone or Joint Infection
- ☐ Diabetes
- ☐ Depression
- ☐ Multiple Sclerosis
- ☐ Stroke
- ☐ Parkinson's Disease
- ☐ Epilepsy
- ☐ Hepatitis
- ☐ Pelvic Inflammatory Disease
- ☐ Ulcers / Gastritis
- ☐ Thyroid Problems
- ☐ Chemical Dependency
- ☐ Smoking
- ☐ Osteoporosis
- ☐ Blood Clots
- ☐ Liver Problems
- ☐ Tuberculosis
- ☐ Autoimmune Disease
- ☐ Cancer:_____
- ☐ Sexually Transmitted disease / HIV / _____
- ☐ Other:_____

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List any allergies (to food, to medications or Latex): _____

_____

Past surgical history (type & date):_____

_____

_____

Which of the following OVER-THE-COUNTER medications have you taken in the last week?

- ☐ Aspirin
- ☐ Laxatives
- ☐ Naproxin / Aleve
- ☐ Tylenol
- ☐ Antacid
- ☐ Advil / Motrin / Ibuprofen
- ☐ Vitamins
- ☐ Mineral Supplements
- ☐ Other:_____

Please list any PRESCRIPTION medication you are currently taking (INCLUDING pills, injections and/or skin patches): _____

_____

_____

Have you ever taken steroid medications for any medical conditions? ____YES ____NO

Have you ever taken blood thinning or anticoagulant medications for any conditions? ____YES ____NO

During the past month, have you been feeling down, depressed, or hopeless? ____YES ____NO

During the past month, have you had little interest or pleasure in doing things? ____YES ____NO

If you answered yes to one or both of the above 2 questions, would you like help? ____YES ____NO

____YES, but not today

Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? ____YES ____NO

Are there any cultural/religious/family beliefs or values we should be aware of in planning/providing your care?

____YES ____NO

Patient-Specific Functional Scale:
Please identify up to 3 important activities that you are
unable to do, or having difficulty with, as a result of your
current problem/diagnosis. (ie: walking, lifting, grocery shopping)
Please circle the number that best applies for each activity
0 = Able to perform activity at the same level as prior to problem
10 = Unable to perform activity

1. Activity:

0 1 2 3 4 5 6 7 8 9 10

No issues — Cannot perform

2. Activity:

0 1 2 3 4 5 6 7 8 9 10

No issues — Cannot perform

3. Activity:

0 1 2 3 4 5 6 7 8 9 10

No issues — Cannot perform