FULL RANGE PT & REHAB SERVICES®
Your Life. Your Goals. Your Way.

Name: _____

Date: _____

Date of Birth: _____

Primary Care Physician: _____

Emergency Contact: _____ **Emergency Contact Phone:** _____

Personal Email Address: _____

Medical History: Check each of the item that relates to your medical history

- ☐ Anemia
- ☐ Back Pain
- ☐ Bronchitis
- ☐ Drink alcohol
- ☐ Gout
- ☐ Hernia
- ☐ Parkinson's
- ☐ Severe/frequent headaches
- ☐ Stroke/TA
- ☐ Vision difficulties
- ☐ Women's health issues
- ☐ Pacemaker
- ☐ Angina
- ☐ Blot clot/Emboli
- ☐ Coronary heart disease
- ☐ Emphysema
- ☐ Hearing difficulties
- ☐ High blood pressure
- ☐ Pneumonia
- ☐ Sleeping problems
- ☐ Thyroid problems
- ☐ Weakness
- ☐ Allergies
- ☐ Asthma
- ☐ Bowel/bladder problems
- ☐ Dizziness or faintness
- ☐ Epilepsy/Seizures
- ☐ Heart attack
- ☐ Kidney Disease
- ☐ Pregnant
- ☐ Smoke Cigarettes, or Other Tobacco Use
- ☐ Varicose Veins
- ☐ Weight loss/energy loss

Medical History: Check each of the area of the body that relates to your medical history

- ☐ Ankles, both
- ☐ Elbows, both
- ☐ Hips, both
- ☐ Knees, both
- ☐ Legs, both
- ☐ Shoulders, both
- ☐ Wrists, both
- ☐ Ankle, left
- ☐ Elbow, left
- ☐ Hip, left
- ☐ Knee, left
- ☐ Leg, left
- ☐ Shoulder, left
- ☐ Wrist, left
- ☐ Ankle, right
- ☐ Elbow, right
- ☐ Hip, right
- ☐ Knee, right
- ☐ Leg, right
- ☐ Shoulder, right
- ☐ Wrist, right

Medical History: Check each of the topics that relate to your medical history

- ☐ Joint replacement — If yes, location: _____
- ☐ Arthritis — If yes, location: _____
- ☐ Pins or metal implant — If yes, location: _____
- ☐ Numbness/tingling/neuropathy — If yes, location: _____

Medical History: Check each of the topics that relate to your medical history

- ☐ Complex regional pain synd.
- ☐ Cancer
- ☐ Diabetes, Type 2
- ☐ Diabetes, Type 1
- ☐ I received P.T. at home
- ☐ I'm caregiver for someone else
- ☐ I use a cane
- ☐ I live alone
- ☐ I use a wheelchair
- ☐ I use a walker
- ☐ Infectious
- ☐ Incontinence
- ☐ Other important issues
- ☐ My home has stairs
- ☐ Pelvic floor
- ☐ Other surgery
- ☐ I received nursing at home
- ☐ Vertigo/balance

Does your diagnosis impact your ability to do your job?

- ☐ I am retired
- ☐ The diagnosis prevents me from working
- ☐ I can only work part time
- ☐ I can work, but with great difficulty
- ☐ I can work, but with minor difficulty
- ☐ The diagnosis does not impact my ability to work
- ☐ Not applicable

Does your diagnosis impact your ability to attend school?

- ☐ The diagnosis prevents me from attending school
- ☐ I am in school, but the diagnosis has a big impact
- ☐ I am in school, but the diagnosis has a minor impact
- ☐ School is normal, but I can't participate in sports
- ☐ School is normal, no impact
- ☐ Not applicable

Other Factors:

How often do you exercise?

- ☐ Never
- ☐ Usually once per week
- ☐ Usually twice per week
- ☐ Usually 3 times per week
- ☐ 4 or more times per week

Does your daily routine, or work, aggravate your injury?

- ☐ No
- ☐ I am unable to participate in my normal routines or work
- ☐ My routine/work usually impacts my injury 1 day per week
- ☐ My routine/work aggravates my injury about 2 days per week
- ☐ My routine/work aggravates my injury 3 or more days per week
- ☐ My routine/work aggravates my injury every day, but I try to cope

Please list current medications, including dosage and route:

Example: Tylenol 2 tabs 325 every 6 hours as needed orally

_____

_____

_____

Check off below what has prompted today's visit

- ☐ Ankles, left
- ☐ Ankle, right
- ☐ Arm, left
- ☐ Arm, right
- ☐ Buttock, left
- ☐ Buttock, right
- ☐ Chest, left
- ☐ Chest, right
- ☐ CRPS, left
- ☐ CRPS, right
- ☐ Elbow, left
- ☐ Elbow, right
- ☐ Feet/toes, left
- ☐ Feet/toes, right
- ☐ Forearm, left
- ☐ Forearm, right
- ☐ Hands/fingers, left
- ☐ Hands/fingers, right
- ☐ Head, left
- ☐ Head, right
- ☐ Hip, left
- ☐ Hip, right
- ☐ Incontinence
- ☐ Jaw, left
- ☐ Jaw, right
- ☐ Knee, left
- ☐ Knee, right
- ☐ Low back, center
- ☐ Low back, left
- ☐ Low back, right
- ☐ Neck, left
- ☐ Neck, right
- ☐ Pelvic floor
- ☐ Shin/calf, left
- ☐ Shin/calf, right
- ☐ Shoulder, left
- ☐ Shoulder, right
- ☐ Spine
- ☐ Thigh, left
- ☐ Thigh, right
- ☐ Upper back, center
- ☐ Upper back, left
- ☐ Upper back, right
- ☐ Vertigo/balance
- ☐ Wrist, left
- ☐ Wrist, right

Is this a reoccurrence of a prior injury?

- ☐ Yes — If yes, what year was the prior injury? _____
- ☐ No

Describe what type of pain you feel:

- ☐ Aching
- ☐ Heavy
- ☐ Burning
- ☐ Numb
- ☐ Constant
- ☐ Pins and needles
- ☐ Cramping
- ☐ Stabbing
- ☐ Deep
- ☐ Throbbing
- ☐ Dull
- ☐ Variable
- ☐ Weak

Rate your pain on a scale of 0-10 (0= no pain, 10= worst pain I've ever felt)

What was the level of your pain, when the injury first occurred? _____
What is your pain level, when it is at it's worst? _____
What is your pain level, when you feel best? _____
What is your pain level, right now? _____

What makes your pain feel worse?

- ☐ Reaching back
- ☐ Twisting
- ☐ Lying flat
- ☐ Lifting anything
- ☐ Getting up out of bed
- ☐ Lifting heavy weights
- ☐ Dressing and grooming
- ☐ Pulling
- ☐ Cooking
- ☐ Raising arm over the head
- ☐ Carrying items
- ☐ Looking up/down
- ☐ Climbing stairs
- ☐ Walking

What relieves your pain?

- ☐ Ice
- ☐ Pain medication
- ☐ Heat
- ☐ Lying flat
- ☐ Stretching
- ☐ Avoiding activity
- ☐ Exercise
- ☐ Nothing

Please document your height and weight:

Height: _____ft _____inches Weight: _____lbs

Falls

How many times have you fallen in the past year? _____

If yes, were you injured? ☐ Yes ☐ No

Tobacco Usage

Do you use tobacco? ☐ Yes ☐ No

If yes, do you:
- ☐ Smoke Tobacco
- ☐ Chew Tobacco
- ☐ Snuff Tobacco
- ☐ All of the above

Have you ever received advice or counseling to help you stop using tobacco?
- ☐ Yes, I have received advice and/or counseling
- ☐ No, I have not received advice and/or counseling

ALLERGIES: _____

Are you latex sensitive? ☐ Yes ☐ No

Please list any surgeries or other conditions for which you have been hospitalized, including dates:

1. _____
2. _____
3. _____

If addition space is needed, please use back of form.

FOR WOMEN: Are you currently pregnant or think you might be pregnant? ☐ Yes ☐ No

Patient Signature_____ **Date:** _____

(for office use only) Clinician Initials_____ **Date**_____