CLIENT HISTORY

Today's date:___/___/____

Name:

_____

Last

_____ _____ _____

First MI Jr/Sr

Street address:_____

_____ _____

City State Zip

Date of Birth:____/____/_____

Sex: ☐ Male ☐ Female

Are you: ☐ Right-handed ☐ Left-handed

Race:

☐ Asian

☐ Native Hawaiian/ Pacific Islander

☐ Black

☐ White

Ethnicity:

☐ Hispanic or Latino

☐ Not Hispanic or Latino

Language: ☐ English understood?

☐ Interpreter needed?

☐ Language spoken: _____

Education:

Highest grade completed: 1 2 3 4 5 6 7 8 9 10 11 12

☐ Some college/technical school

☐ College graduate

☐ Graduate school/advanced degree

SOCIAL HISTORY

Cultural/Religious:

Any customs or religious beliefs or wishes that may affect care?_____

_____

With whom do you live?_____

Have you completed an advanced directive?

☐ Yes ☐ No

Who referred you to our practice?

_____

Employment/Work(Job/School/Play)

☐ Working full-time outside of home

☐ Working part-time outside of home

☐ Working full-time from home

☐ Working part-time from home

☐ Homemaker

☐ Student

☐ Retired

☐ Unemployment

Occupation: _____

LIVING ENVIRONMENT

Does your home have:

☐ Stairs, no railing
☐ Stairs, railing
☐ Ramps
☐ Elevator
☐ Uneven terrain
☐ Assistive devices

Do you use:

☐ Cane
☐ Walker or rollator
☐ Manual wheelchair
☐ Motorized wheelchair
☐ Glasses, hearing aids
☐ Other: _____

Where do you live?

☐ Private home
☐ Private apartment
☐ Rented room
☐ Assisted living
☐ Homeless
☐ Nursing home
☐ Hospice
☐ Board and care

GENERAL HEALTH STATUS

Please rate your overall health:

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Have you had any major life changes within the past year? ☐ Yes ☐ No

SOCIAL/HEALTH HABITS

Smoking

Currently smoke tobacco? ☐ Yes ☐ No

☐ Cigarettes: # of packs/day ____

☐ Cigars/Pipes: # per day ____

Smoked in past? ☐ Yes Year quit: _____ ☐ No

Alcohol

How many days per week do you drink beer, wine, or other alcoholic beverages, on average? _____

How many drinks do you have, on an average day? ___

Exercise

Do you exercise beyond normal daily activities and chores? ☐ Yes Describe the exercise: _____

How many days/week? _____

How many minutes/day? _____

☐ No

FAMILY HISTORY (Check all that apply)

☐ Heart disease
☐ Hypertension
☐ Stroke
☐ Diabetes
☐ Cancer
☐ Psychological
☐ Arthritis
☐ Osteoporosis
☐ Other: _____

Please indicate relationship and age of onset if known:

_____
_____
_____

MEDICAL/SURGICAL HISTORY

Please check if you have ever had:

☐ Arthritis
☐ Multiple sclerosis
☐ Fractures
☐ Muscular dystrophy
☐ Osteoporosis
☐ Seizures/epilepsy
☐ Blood disorders
☐ Parkinson disease
☐ Circulation problems
☐ Developmental problems
☐ Heart problems
☐ Thyroid problems
☐ High blood pressure
☐ Cancer
☐ Lung problems
☐ Infectious disease
☐ Stroke
☐ Kidney problems
☐ Diabetes
☐ Repeated infections
☐ Hypoglycemia
☐ Ulcers
☐ Head injury
☐ Skin diseases
☐ Depression
☐ Other:_____

Within the past year, have you had any of the following symptoms? (Check all that apply)

☐ Chest pain
☐ Difficulty sleeping
☐ Heart palpitations
☐ Loss of appetite
☐ Cough
☐ Nausea/vomiting
☐ Hoarseness
☐ Difficulty swallowing
☐ Shortness of breath
☐ Bowel problems
☐ Dizziness or blackouts
☐ Weight loss/gain

☐ Coordination problems ☐ Urinary problems

☐ Weakness in arms/legs ☐ Fever/chills/sweats

☐ Loss of balance ☐ Headaches

☐ Difficulty walking ☐ Hearing problems

☐ Joint pain/swelling ☐ Vision problems

☐ Pain at night ☐ Other:

_____

Have you ever had surgery? ☐ Yes ☐ No

If yes, please describe and include dates:

_____

_____

_____

For men only:

Have you been diagnosed with prostate disease?

☐ Yes ☐ No

For women only:

Have you been diagnosed with:

Pelvic inflammatory disease? ☐ Yes ☐ No

Endometriosis? ☐ Yes ☐ No

Trouble with your period? ☐ Yes ☐ No

Complicated pregnancies/deliveries? ☐ Yes ☐ No

Pregnant? ☐ Yes ☐ No

Other Ob-gyn difficulties? ☐ Yes ☐ No

Please list:

_____

CURRENT CONDITION(S)/CHIEF COMPLAINT(S)

Describe the problem(s) for which you seek physical therapy:

_____

_____

When did the problem(s) begin (date)?

_____

What happened?

_____

Have you ever had the problem(s) before?

☐ Yes What did you do?

_____

Did it get better? ☐ Yes ☐ No

How long did it last?

_____

☐ No

How are you taking care of the problem now?

_____

_____

What are your goals for physical therapy?

_____

_____

Are you seeing anyone else for the problem(s)?

☐ Yes Please indicate which health care professional:

_____

☐ No

FUNCTIONAL STATUS/ACTIVITY LEVEL

(Check all that apply)

☐ Difficulty with locomotion/movement

☐ Difficulty with self-care

☐ Difficulty with home management

☐ Difficulty with community and work activities

MEDICATIONS

Do you take any prescription medication?

☐ Yes ☐ No

Please list:

_____

_____

_____

Do you take any nonprescription medication?

☐ Yes ☐ No

Please list:

_____

_____

Do you take any medication for the condition for which you are seeing the physical therapist?

☐ Yes ☐ No

Please list:

_____

_____

OTHER CLINICAL TESTS

Within the past year, have you had any diagnostic testings done?

☐ Yes ☐ No

Please list:

_____

_____