PT SERVICES @ Droyers Point

To ensure you receive a complete and thorough evaluation, kindly provide us with important background information. If you don't understand a question, leave blank and your therapist will assist you. Further questions may be asked of you as needed during your interview.

Name:_____Occupation:_____
Address: _____
Date of Birth: _____ Referred By:_____
Height: _____Weight: _____ Blood Pressure: _____

Contact numbers:
Home: _____OK to leave message? Yes No
Work: _____ OK to leave message? Yes No
Mobile: _____ OK to leave message? Yes No
Email: _____ OK to contact me ? Yes No

My preferred method of communication/appointment confirmations is: (please circle)
Home Phone Cell phone Text Email

What is the reason you are here today?_____

Are you currently under the care of any of the following: (please circle)
Medical Doctor (MD) Psychiatrist/Psychologist Chiropractor
Osteopath (DO) Nurse/ Nurse Practitioner Other: (please list)_____
Dentist P.T./O.T./S.T. _____

Date of last Physical Examination:
If you have seen any of the above for the past 3 months, please describe for what reason (pregnancy, illness, medical condition, physical, routine , etc.)
_____
_____

My regular exercise is/are: _____
My goals for exercise is/are:_____

How many hours do you usually sleep at night : _____
What time do you usually go to bed?_____What time do you usually wake up?_____
How would you describe your sleep quality: ___ Great ___Good ___ Poor
Do you have trouble: ___falling asleep ___staying asleep ___ waking up
How do you usually sleep? ____back ___stomach ___sides
How many times do you usually get up to go to the bathroom at night? _____

Are you currently working? ( )YES ___ Full time ____ Part time ( ) NO
What are your main activities at work?_____

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How long is your commute to work?_____ ( ) drive ( ) mass transit

ALLERGIES:

Yes No Latex

Yes No Have you ever had an allergy test?

Yes No Have you ever taken allergy shots?

Yes No If yes, are you still taking them?

How much relief from shots? ( ) Min ( ) partial ( ) significant

Yes No Medications Allergies, if so please list:

_____

_____

_____

Have you ever been diagnosed with any of the following conditions:

Diagnosed

Within the past 12 months / More than 12 months ago

Yes No Cancer If Yes, what kind_____

Yes No Heart Condition If yes, what kind_____

Yes No High Blood Pressure

Yes No DVT (blood clots in the legs)

Yes No Arterial Blockage of the leg

Yes No Stroke (including TIA, mini stroke)

Yes No Anemia/ low blood levels

Yes No Asthma

Yes No Emphysema

Yes No Chemical Dependency (alcoholism)

Yes No Depression

Yes No Tuberculosis

Yes No Thyroid problems (hyper/high) (Hypo/Low)

Yes No Kidney if Yes, what kind_____

Yes No Diabetes diagnosed before 18 yrs. ____after 18 yrs. ___

Yes No Multiple Sclerosis

Yes No Rheumatoid Arthritis

Yes No Degenerative Osteoarthritis (wear and tear)

Yes No Gout

Yes No Ankylosing Spondylitis

Yes No Hepatitis

Yes No Stomach/Duodenal ulcers

Yes No Epilepsy/ Seizures

Yes No Headaches (more than 1 per week)

Yes No Endometriosis

Yes No Urinary incontinence

Yes No Osteoporosis

Yes No Infections urinary tract/bladder (3 episodes or more during the past 12 months)

Yes No Pneumonia

Yes No Bone or Joint infection

Yes No Pelvic Inflammatory disease

Yes No Kidney infection

Other infection. Please list: _____

Other illnesses diagnosed by a physician: (please list): _____

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Yes No During the past month have you been feeling down, depressed or hopeless
Yes No During the past month have you been bothered by having little interest or pleasure in doing things
Yes No Do you ever feel unsafe at home or has anyone hit you or tried to injure you in anyway

Please list all Surgeries/Hospitalizations include date and reason:

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please describe any significant injuries for which you have been treated (including fractures, dislocations and sprains) and the approximate date of injury:

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please describe the condition you are seeking treatment for and give brief history including onset:_____
_____

What are your goals for treatment? _____
_____

What other treatments have you tried before? _____
_____

Do you have any pain? ( ) Yes ( ) No
What makes your pain worse? ( ) sitting ( ) standing ( ) walking ( ) sleeping
( ) reaching ( ) lifting ( ) bending ( ) Squatting ( ) moving ( ) sedentary
Other things that make your pain worse: _____
What makes your pain better? :_____

Has anyone in your immediate family (parents, brothers, sisters) ever been treated/diagnosed with any of the following?

Yes No Diabetes	Yes No Cancer What kind_____
Yes No Heart Disease	Yes No Chemical Dependency (e.g. Alcoholism)
Yes No High Blood Pressure	Yes No Depression
Yes No Stroke	Yes No Kidney Disease

Yes No Inflammatory Arthritis (Rheumatoid, Ankylosing)

Medications:	**Physician prescribed**	**Taken the past week**	**Last Time Taken**
Anti-inflammatory (Advil, Motrin, Ibuprofen, etc.)	YES NO	YES NO	_____

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Aspirin	YES NO	YES NO	_____
Tylenol	YES NO	YES NO	_____
Stomach Ulcer medication	YES NO	YES NO	_____
Vitamins/Mineral supplements	YES NO	YES NO	_____
Herbal/Remedies	YES NO	YES NO	_____

Please list any other physician prescribed medication you are currently taking (Including pills, injections and/or skin patches)

_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____

How much caffeinated coffee or caffeine containing beverages do you drink per day?
1 cup of coffee=1 cup; 2 cups of tea=1 cup 3 cans of soda=1 cup
( ) Zero to 2 cups
( ) 2 cups or more
Tobacco use: How many packs do you smoke per day?____for how many years_____If quit when:_____
How many days per week do you drink alcohol?_____
If one drink equals one beer or glass of wine, how much do you drink at an average sitting?_____

Have you recently noted any of the following :

YES NO weight loss/gain
YES NO nausea /vomiting
YES NO dizziness/lightheadedness
YES NO fatigue
YES NO weakness
YES NO fever/chills/sweats
YES NO numbness or tingling
YES NO tremors
YES NO seizures
YES NO double vision
YES NO loss of vision
YES NO eye redness
YES NO skin rash
YES NO problems sleeping
YES NO sexual difficulties
YES NO night sweats
YES NO hearing problems

YES NO joint/muscle swelling
YES NO easy bruising
YES NO excessive bleeding
YES NO difficulty breathing
YES NO regular cough
YES NO arm/leg swelling
YES NO heart racing in your chest
YES NO swelling
YES NO hearburn/indigestion
YES NO constipation/diarrhea
YES NO blood in stools
YES NO post menopause
YES NO problems urinating (difficulty, pain)
YES NO Urinary incontinence
YES NO Blood in the urine
YES NO pregnant or you think you might be pregnant
YES NO stress at home or at work

Demographic Information:
Gender: ( ) Male ( ) Female Race: _____

Marital Status:
( ) Single ( ) Married ( ) Separated ( ) Divorced ( ) Widowed

PT Services requires 24 hours notice of any cancellations. If notification is not given, client will be charged for the treatment session.

Patient Signature: _____ Date: _____