Bodies in Balance Physical Therapy

Patient Name: _____ Date of Birth: _____ Age: _____

SYMPTOMS:

Please briefly describe your symptoms? _____

_____

When and how did your symptoms begin? _____

_____

How are your symptoms changing? **Please select one of the following:**

Getting Better Getting Worse Not Changing

Regarding FUNCTION:

Please list specific **tasks that are affected/or you are unable to do** which you could do 6 months ago (i.e.: grocery shopping, climbing stairs, sleeping, cleaning the house…):_____

_____

What are **YOUR goals** for physical therapy? _____

_____

TREATMENTS: Tell us about other treatment you have previously received for this problem:

- Physical Therapy- _____
- Chiropractic Therapy- _____
- Other- _____

Please select the following tests if you have performed them due to your symptoms:

- MRI- Date: _____
- X-Ray- Date: _____
- CT Scan- Date: _____
- Other- Indicate test and date: _____

Other IMPORTANT SCREENS:

Depression Screening:

Over the last 2 weeks, how often have you been bothered by the following problems?	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest of pleasure in doing things	**0**	**+1**	**+2**	**+3**
2. Feeling down, depressed or hopeless	**0**	**+1**	**+2**	**+3**

-Do you have **any cultural / religious beliefs** that would affect your care**? Yes / No**

-Are you **receiving ANY Home Health Care of Hospice services? Yes / No**

-Please **see Elder Abuse Screen** and **let your physical therapist know if you need assistance** or **resources regarding abuse.**

Patient Name: _____ Height: _____ Weight: _____

Please Circle

Allergies	Yes / No	Dizzy Spells	Yes / No	MRSA	Yes / No
Anemia	Yes / No	Emphysema/Bronchitis	Yes / No	Multiple Sclerosis	Yes / No
Anxiety	Yes / No	Fibromyalgia	Yes / No	Muscular Disease	Yes / No
Arthritis	Yes / No	Fractures	Yes / No	Osteoporosis	Yes / No
Asthma	Yes / No	Gallbladder Problems	Yes / No	Parkinson's	Yes / No
Autoimmune Disease	Yes / No	Headaches	Yes / No	Rheumatoid Arthritis	Yes / No
Cancer	Yes / No	Hearing Impairment	Yes / No	Seizures	Yes / No
Cardiac Conditions	Yes / No	Hepatitis	Yes / No	Smoking	Yes / No
Cardiac Pacemaker	Yes / No	High Cholesterol	Yes / No	Speech Problems	Yes / No
Chemical Dependency	Yes / No	High/Low Blood Pressure	Yes / No	Strokes	Yes / No
Circulation Problems	Yes / No	HIV/AIDS	Yes / No	Thyroid Disease	Yes / No
Currently Pregnant	Yes / No	Incontinence	Yes / No	Tuberculosis	Yes / No
Depression	Yes / No	Kidney Problems	Yes / No	Vision Problems	Yes / No
Diabetes	Yes / No	Metal Implants	Yes / No	Glaucoma	Yes / No

If "Yes" to any of the above, please explain and give approximate dates / describe any other conditions

_____

_____

_____

Fall Risk Assessment:

- Injury because of a fall in the past year? **Yes / No**
- Two or more fall in the last year? **Yes / No**
- Do you feel that you are not walking as well as you were 6 months ago? **Yes / No**
- Do you feel dizzy or have feelings that the room is spinning? **Yes / No**

Surgical History	**Dates**

You may give a copy of your medical list to us or ask front staff for referral copy. Otherwise please list current medications:

Current Medications	**Reasons for Taking**	**Dosage**

Patient Name: _____

PAIN: It is necessary to determine if you are experiencing any pain, as well as the type and location of the pain.

Do you have pain? Yes / No (If not skip this section)

If yes, please rate your pain during the last 2 weeks by circling a number

No Pain 1 2 3 4 5 6 7 8 9 10 **Unbearable**

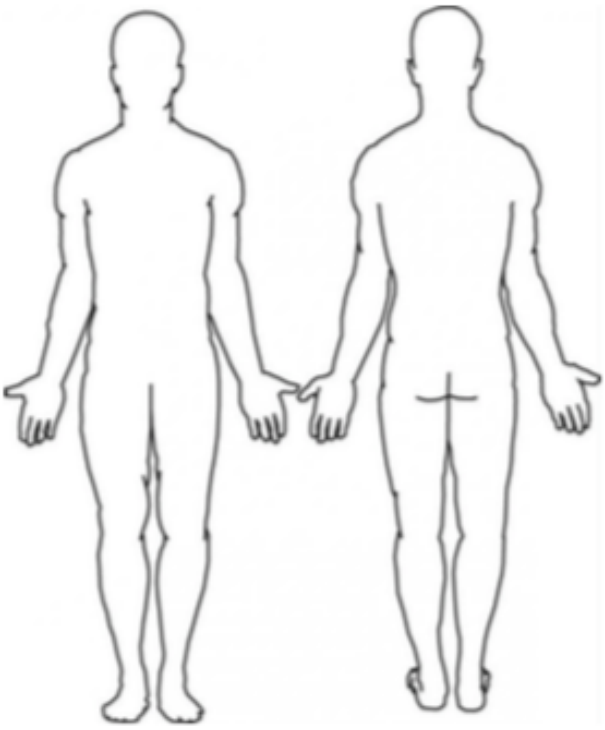
What activities make your pain worse? _____

_____

What helps ease your pain? _____

_____

Please mark your pain on the body diagram:



Patient Signature: _____ Date: _____