Bodies in Balance Physical Therapy

Name: _____ Date of Birth: _____ Height: _____ Weight: _____

SYMPTOMS:

What brings you to physical therapy?

When and how did your symptoms begin?

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

What are daily tasks that your symptoms are affecting? (ex: grocery shopping, climbing stairs, sleeping, cleaning the house…):

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

- Physical Therapy-
- Other-

FALL RISK ASSESSMENT:

- Injury because of a fall in the past year? Please click here to select one:
- Two or more falls in the last year? Please click here to select one:

DO YOU HAVE PAIN? Yes / No (If not skip this section) Please click here to select one:

If yes, please CIRCLE your pain IN REGARD TO WHAT BRINGS YOU TO THERAPY during the last 2 weeks

Please click here to select one:

What activities make your pain worse?

What helps ease your pain?

SURGICAL HISTORY: Provide us with a copy of your surgical history or fill in below. Skip if completed online.

SURGERY	DATE(S)

MEDICATIONS: I verify I have provided a list of my current medications. **Please initial _____**

OR I verify the list of medications my doctor provided is accurate. **Please initial _____**

Do you have **any cultural / religious beliefs** that would affect your care**?** Please click here to select one:

Are you **receiving ANY Home Health Care or Hospice services?** Please click here to select one:

Patient Signature: _____ Date: _____

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MEDICAL HISTORY: **Please Select Your Answer**

Allergies	Yes/No	Diabetes	Yes/No	Metal Implants	Yes/No
Anemia	Yes/No	Dizzy Spells	Yes/No	MRSA	Yes/No
Anxiety	Yes/No	Emphysema/Bronchitis	Yes/No	Multiple Sclerosis	Yes/No
Arthritis	Yes/No	Fibromyalgia	Yes/No	Muscular Disease	Yes/No
Asthma	Yes/No	Fractures	Yes/No	Osteoporosis	Yes/No
Autoimmune Disease	Yes/No	Gallbladder Problems	Yes/No	Parkinson's	Yes/No
Cancer	Yes/No	Headaches	Yes/No	Rheumatoid Arthritis	Yes/No
Cardiac Conditions	Yes/No	Hearing Impairment	Yes/No	Seizures	Yes/No
Cardiac Pacemaker	Yes/No	Hepatitis	Yes/No	Smoking	Yes/No
Chemical Dependency	Yes/No	High Cholesterol	Yes/No	Speech Problems	Yes/No
Circulation Problems	Yes/No	High/Low Blood Pressure	Yes/No	Strokes	Yes/No
COVID-19	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

Bodies In Balance Physical Therapy Depression Screening

Name: _____

Please disregard this questionnaire if you have a diagnosis of depression. Circle which answer best fits you.

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 or pleasure in doing things	0	+1	+2	+3
2. Feeling down, depressed or hopeless	0	+1	+2	+3

IF you scored 0 on the two questions above you can stop here. If you scored 1 or above please continue to questions 3-9.

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
3. Trouble falling asleep, staying asleep or sleeping too much	0	+1	+2	+3
4. Feeling tired or having little energy	0	+1	+2	+3
5. Poor appetite or overeating	0	+1	+2	+3
6. Feeling bad about yourself or that you're a failure or have let yourself or your family down	0	+1	+2	+3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	+1	+2	+3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite; being so fidgety or restless that you have been moving around a lot more than usual	0	+1	+2	+3
9. Thoughts that you would be better off dead or of hurting yourself in some way.	0	+1	+2	+3