Bodies in Balance Physical Therapy

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

Home Address: _____

SYMPTOMS:

Please briefly describe your symptoms? _____

_____

When and how did your symptoms begin? _____

_____

How often do you experience your symptoms? **Please select one of the following:**

- ◯ Constantly (76-100% of the day)
- ◯ Frequently (51-75% of the day)
- ◯ Occasionally (26-50% of the day)
- ◯ Intermittently (0-25% of the day)

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

- ◯ Getting Better
- ◯ Getting Worse
- ◯ Not Changing

How much have your symptoms interfered with your usual daily activities? (Including home and out-of-home work) **Please select one of the following:**

- ◯ Not at all
- ◯ A little bit
- ◯ Extremely
- ◯ Moderately
- ◯ Quite a bit

What work or hobbies do you do that is affected by your symptoms? _____

_____

Regarding FUNCTION:

Please list specific **tasks that you are unable to do now** 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:

Please select all the following **therapy treatments** you have previously received:

- ◯ Physical Therapy- What year(s) was your treatment? _____
- ◯ Chiropractic Therapy- What ear was your treatment? _____
- ◯ Other- _____

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

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

Overall Health: In general, how would you rate your health right now: Excellent/Very Good/Fair/Poor **(circle)**

Patient Name: Date of Birth:

Height:_____ Weight:_____ BMI:_____ (therapist will calculate)

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**

Current Medications	**Reasons for taking**	**Dosage**

Patient Name: _____ Date of Birth: _____

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											**Unbearable**
☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐	8 ☐	9 ☐	10 ☐	☐

What activities make your pain worse? _____

_____

What helps ease your pain? _____

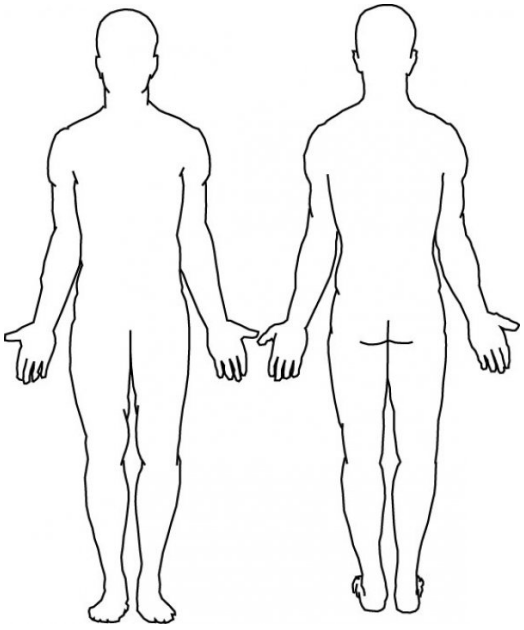
_____

Please select what **best** describes your pain: The pain is…

☐ **Constant** ☐ **Comes and Goes** ☐ **Sharp**

☐ **Dull** ☐ **Aching** ☐ **Unyielding**

Description of Pain:



_____

_____

_____

_____

_____

_____

_____

Please mark the exact location(s) of your pain on the body diagram above.

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**

_____ Date: _____

Patient Signature: