**THOMAS F. PRICE, LPT**
**PROFESSIONAL REHAB KARE**

**NAME:________________________________________**

**Height _______ Weight ______ Date of Birth ______________**

**Blood Pressure at last doctor's visit: ___________**

**Are you: ( ) Righthanded ( ) Lefthanded**

**Employment:**
**___ 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 ___Unemployed**

**Occupation:_____________________________________**

**Who referred you to Physical Therapy:_________________**

**Does your home have:**

**____Stairs, no railing**
**____Stairs, w/railing**
**____Ramps**
**____Elevator**
**____Uneven Terrain**
**____Other Obstacles: _______________________**

**Do you use:**

**____Cane**
**____Walker or rollator**
**____Manual Wheelchair**
**____Motorized wheelchair**
**____Other________________**

**General Health**

**Please rate your health:**
**____ Excellent ____Good ____Fair ____Poor**

**Have you had any major life changes during the past Year? (such as a new baby, job change, death of a family member)**
**_____Yes ______No**

**Health Habits**

**Do you exercise regularly? ________ Yes _______No**
**If yes, how often and what type of activities?**
**__________________________________________**

**Do you use tobacco products? _______ Yes ________ No**

Family History (indicate whether mother, father, brother/sister, aunt/uncle, or grandmother/grandfather had any of the following disorders and provide age of onset if known)

Heart disease: ________________________________________
Hypertension: ________________________________________
Stroke: ______________________________________________
Diabetes: ___________________________________________
Cancer:_____________________________________________
Other: ______________________________________________

Medications:

Do you take any prescription medications? ___ Yes ___ No
If yes, please list:
Medication Dosage Frequency
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
__
_____________________________________________________
_____________________________________________________

Do you have any allergies? ___Yes ___No
If yes, please list: _______________________________________
Do you take any nonprescription medications or supplements?
_______ Yes _________No
If yes, what?_______________________________________

Medical History:
Please check if you have ever had:

____ Infectious disease (such as tuberculosis, hepatitis)
____ Arthritis
____ Blood disorders
____ Broken bones/ fractures
____ Cancer
____ Circulation/ vascular problems
____ Depression / Psychological problems
____ Developmental or growth problems
____ Diabetes/high blood sugar
____ Eating or Nutritional Disorders
____ Kidney problems
____ Low blood sugar/ hypoglycemia
____ Lung problems
____ Multiple sclerosis
____ Muscular dystrophy
____ Osteoporosis
____ Parkinson's diseases
____ Repeated infections
____ Seizures/epilepsy
____ Skin diseases
____ Head injury

____ Stroke
____ Thyroid problems
____ Ulcers/stomach problems
____ Heart problems
____ High blood pressure
____ Other: ________________

For Men:
Have you been diagnosed with prostate disease?
______ Yes ______ No

For Women:
Pregnant, or think you might be pregnant?
______ Yes ______ No

Have you ever had surgery? ____ Yes ____ No
If yes, please describe, and include dates:

Month/Year
________________________________ ____/______
________________________________ ____/______
________________________________ ____/______
________________________________ ____/______

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

___ Bowel problems
___ Chest pain
___ Coordination problems
___ Cough
___ Difficulty sleeping
___ Difficulty swallowing
___ Difficulty walking
___ Dizziness or blackouts
___ Fever/chills/ sweats
___ Headaches
___ Hearing problems
___ Heart palpatations
___ Hoarseness
___ Joint pain or swelling
___ Loss of appetite
___ Loss of balance
___ Nausea/vomiting
___ Pain at night
___ Shortness of breath
___ Urinary problems
___ Vision problems
___ Weakness in arms or legs
___ Weight loss/gain

Other:________________________________________

Current Limitation (Check all that apply)
___ Difficulty with bed mobility
___ Difficulty with transfers (such as moving from bed to chair, from bed to commode)
___ Difficulty walking
___ on level surface ___ on stairs ___ on ramps
___ on uneven terrain
___ Difficulty with self-care (such as bathing, dressing, eating, toileting) ___ Difficulty with home management (such as household chores, shopping, driving/transportation)

___ Difficulty with community and work activities/integration
___ Difficulty work/school
___ Difficulty recreation or play activity

**History of Current Problem(s)**
When did the problem(s) begin? ____/____/____
What happened?
___________________________________________________________
__________________________________________________________________________
____________________________________________

Have you ever had the problem(s) before?
___ Yes _____ No

What makes the problem(s) worse_____________________________
_____________________________________________________

What activities are you not able to do now that you could do before the problem(s)? (Please be as specific as you can; for instance "Unable to reach over my head")
__________________________________________________________________________
____________________________________________

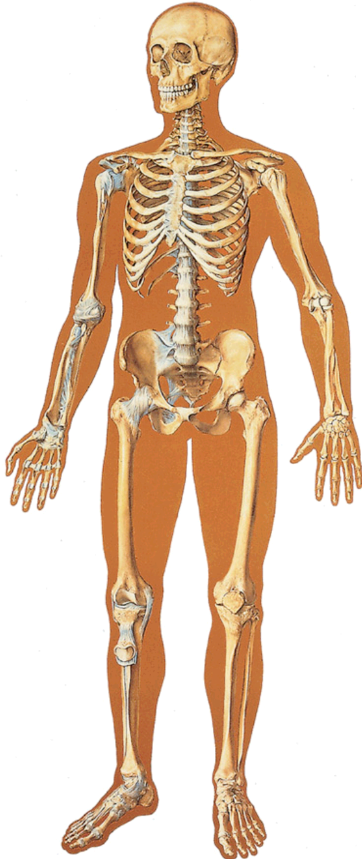
What are your goals for physical therapy? ____________________
________________________________________________________

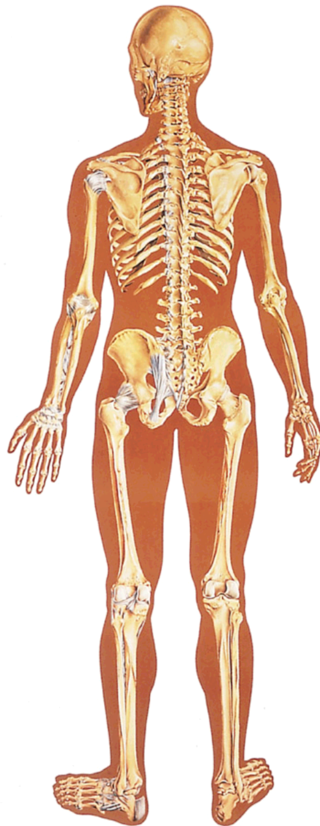
Are you seeing anyone else for the problem? (Check all that apply.)

__Acupuncturist
__ Cardiologist
__ Chiropractor
__ Dentist
__ Family practitioner
__ Internist
__ Massage therapist
__ Neurologist
__ Obstetrician/Gynecologist
__ Occupational therapist
__ Orthopedist
__ Osteopath
__ Pediatrician
__ Podiatrist
__ Primary care physician
__ Rheumatologist
__ Other: _________________
__ Speech Therapist

**Please indicate painful areas**

**FRONT** **BACK**





**It is important that we have a measure of your pain. Please rate the level of your pain on the following scale.**

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **At present:** | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| **At best:** | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| **At worst:** | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| | (no pain) | | | | (moderate pain) | | | | | (extreme agony) | |

**Which of these words describe your pain? (Circle all that apply)**

**Sharp Dull Burning Aching Tingling**

**Numb Constant Variable Radiating (moves)**

**SIGNATURE:________________________________DATE:____________________**