South River Rehabilitation & Performance

Please take a few minutes to answer the following questions about your health and lifestyle to assist us in expediting your evaluation:

Patient's name_____ Date of birth_____

Physician:_____ Follow up appointment with physician:_____

Age:_____ Height:_____ Weight:_____

How do you learn best? _____verbally _____written _____visually _____demonstration

Reason for coming to Physical Therapy: _____

_____

_____

When did your symptoms start? _____

Is this resulting from (circle one): Accident Injury Recent Surgery Sudden Onset

Diagnostic Tests (circle all that apply): X-rays MRI CT-Scan Where?:_____

Do you have any of the following? (Circle all that apply):

Diabetes High Blood Pressure Heart problems Heart attack Cancer

Lung/respiratory problems Osteoarthritis Rheumatoid arthritis Asthma

Bladder Dysfunction Allergies (please list):_____

Other (please list):_____

Do you currently take any medication on a regular basis? (please list): _____

_____

Have you ever received physical therapy before (circle one): Yes No

If so, where? _____ When? _____

For what condition: _____ Result of therapy:_____

Living conditions (circle all that apply)

Apartment House Multiple family dwelling Flights of stairs: #_____

Elevator Live with family Live Alone Live with others

Occupation: _____ Currently working? (circle one) Yes No

Please describe any pain using the following:

Location: _____

What makes your pain worse? _____

What makes your pain better? _____

What time of day is your pain the worst? _____

Description (circle all that apply): Sharp Dull Ache Tingling Numbness Radiating

Rate your pain on a scale of 0-10. 0 is no pain, 10 is the worst pain you have ever felt:_____

Is your pain (circle one) constant intermittent

Does your pain prevent you from sleeping or wake you up in the middle of the night? Yes No

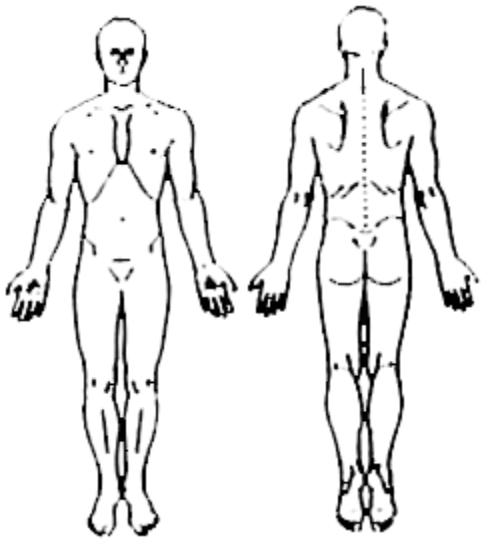
What activities do you feel you cannot participate in because of this pain or condition?

_____

What are your goals and/or expectations for Physical Therapy? _____

_____

Please mark where your pain is located, include a description (pain, burning, tingling, numbness, dull ache, other):



Over the past 2 weeks have you had little interest or pleasure in doing things? Yes No

Over the past 2 weeks have you been feeling down, depressed or hopeless? Yes No