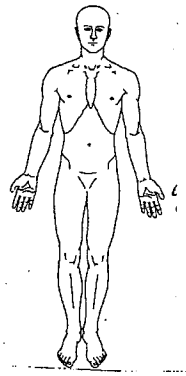
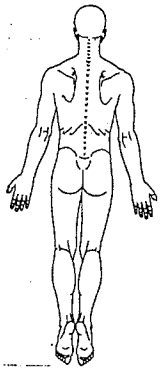
Foothills Physical Therapy
Patient Information

Name:_____ Date:_____

Using the symbols given below, mark the areas on your body where you feel the described sensations. Include all affected areas. If none of these words describe your symptoms, just circle the affected areas.
-ACHE: XXXXX
-BURNING: --------
-STABBING: //////////
-NUMBNESS or
- PINS AND NEEDLES: 000000





Is your condition getting better, getting worse or staying the same? _____
Occupation: _____ Presently working? _____ Hours per week you work? _____
Age: ____ Weight_____ Height_____ *(circle one)* Right Handed Left Handed
If applicable: Date of Surgery_____ Date of Injury_____

Circle the appropriate number or answer for the following questions:

1. AVERAGE PAIN LEVEL:

10 9 8 7 6 5 4 3 2 1 0

I have INTOLERABLE pain with all activities — I have MODERATE pain with half of my activities — I have NO pain with any activity

2. SEVERITY: How much is this injury/condition "messing up" your life as a whole? Take into consideration all areas of your life.

100% 90% 80% 70% 60% 50% 40% 30% 20% 10% 0%

My life is SEVERELY affected — My life is UNAFFECTED

3. JOB/WORK: How is this injury/condition affecting your ability to do your regular job at your full capacity?

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

I am UNABLE to work — I am on LIGHT duty — I can do my full job WITHOUT DIFFICULTY

4. DAILY TASKS: The ability to get out of bed at your usual time, do chores such as cleaning, bringing in groceries, cooking, bringing in the wood, shoveling, mowing the lawn, driving to do errands or any other physical activity you do on a daily basis other than work or recreation.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

I can't do ANY daily tasks — I can do ALL daily tasks

5. RECREATION: Your ability to do activities that are enjoyable to you (sports, fitness, routines, vacations, social engagements, sex, etc.)

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

I can't take part in ANY of my activities — I can take part in ALL of my activities

PLEASE COMPLETE OTHER SIDE

Name: _____

Have you or any immediate family member ever been diagnosed with: (Please Circle Yes or No, Self and/or Family)

Cancer	yes	no	self	family	Angina/Chest Pain	yes	no	self	family
High Blood Pressure	yes	no	self	family	Stroke	yes	no	self	family
Diabetes	yes	no	self	family	Arthritis	yes	no	self	family
Heart Disease	yes	no	self	family					

Have you had or recently experienced:

Nausea/Vomiting	yes	no	Fever/Chills/Sweats	yes	no
Numbness/tingling	yes	no	Muscular Weakness	yes	no
Fainting Spells	yes	no	Dizziness	yes	no
Night Pain	yes	no	Headaches	yes	no
Surgery	yes	no	Hospitalization	yes	no
Unexplained weight loss	yes	no	Bowel/bladder changes	yes	no

If yes, please explain:_____

_____

Do you have a history of:

Shortness of Breath	yes	no	Allergies	yes	no
Asthma	yes	no	Bronchitis	yes	no
Kidney Disease/stone	yes	no	Polio	yes	no
Emphysema	yes	no	Anemia	yes	no
Rheumatic Fever	yes	no	Ulcers	yes	no
Seizures	yes	no	Other illnesses	yes	no

Have you had any recent illnesses, including upper respiratory infections, flu, or urinary tract infections? yes no

Do you smoke? yes no If yes, how many packs per day? _____ For how many years? _____

Do you use alcohol? yes no If yes, how many drinks per day? _____ How many per week? _____

Do you consume caffeine? yes no Of yes, how many cups per day? _____

Do you have any allergies to latex? yes no

Do you currently use or have you ever used a C-PAP Machine? Yes No

Please list your medications:_____

_____

How often do you feel stress is a significant factor in your life? (circle one)

Never Seldom Occasionally Regularly Always

In general, do you sleep well? yes no

Please list leisure activities and current exercise routines:_____

_____

Date of last completed physical examination: Month _____ Year _____

Woman: Date of last menstrual period: _____ Might you be pregnant? yes no

What do you want Physical Therapy to do for you? _____

_____