

Date: \_\_\_/\_\_\_/\_\_\_ Patient Name: \_\_\_\_\_

Physical/Occupational/Speech Therapy Summary (75pts)

Do you have any known drug allergies? (nkda)  Yes  No If YES, please list drugs you are allergic to: \_\_\_\_\_

Are you presently taking Medication?  Yes  No If YES, please list medications below and what you are taking them for.

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_
- 5. \_\_\_\_\_
- 6. \_\_\_\_\_
- 7. \_\_\_\_\_
- 8. \_\_\_\_\_
- 9. \_\_\_\_\_
- 10. \_\_\_\_\_

Please list all major surgeries you have had and the year they were performed:

Type of Surgery	Date	Type of Surgery	Date

Have you had physical/occupational/speech therapy treatment within the last 60 days?  No  Yes

Have you been recently hospitalized?  No  Yes

History (75sr)

Age: \_\_\_  Male  Female Are you  right or  left hand dominant?  Ambidextrous?

Height: \_\_\_ ft \_\_\_ inches Weight: \_\_\_\_\_ lbs Are you satisfied with your weight?  Yes  No

Date of injury or onset of present symptoms: \_\_\_/\_\_\_/\_\_\_ Have you ever had these symptoms before?  Yes  No

Check one or more of the following that apply to your present condition:

- Work related injury
- Motor vehicle accident
- Injury related to lifting
- Recurrence of previous injury
- Athletic / recreational injury
- Injury related to falling
- Have you been hospitalized in the last 3 months?
- Surgery (Specify): \_\_\_\_\_

What were you doing when you were injured or experienced the onset of your present condition and how did it happen?

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Systems Review: Please check only the conditions you currently have

Constitutional

- Recent fevers/sweats
- Unexplained weight loss/gain
- Unexplained fatigue/weakness
- HIV
- Hepatitis A, B, or C
- Diabetes
- Cancer

Respiratory

- Cough/wheeze
- Coughing up blood
- Asthma

Skin

- Rash
- Sores
- MRSA

**Eyes**

- Change in vision
- Wear glasses

**Gastrointestinal**

- Blood or change in bowel movement
- Nausea/vomiting/diarrhea

**Neurological**

- Headaches
- Numbness
- Tremors
- Poor balance

**Ears / Nose / Throat / Mouth**

- Difficulty hearing/ringing in ears
- Hay fever/allergies/ ongestion
- Trouble swallowing

**Endo**

- Cold/heat intolerance
- Increased thirst/appetite

**Blood / Lymphatic**

- Unexplained lumps
- Easy bruising or bleeding

**Genitourinary**

- Painful/bloody urination
- Leaking urine
- Night time urination
- Discharge: penis or vagina
- Unusual vaginal bleeding
- Concern with sexual functions

**Psychiatric**

- Anxiety
- Sleep problem
- Depression

**Cardiovascular**

- Chest pains/discomfort
- Palpitations/irregular heartbeat
- Shortness of breath
- High Blood Pressure

**Musculoskeletal**

- Muscle/joint pain
- Recent back pain
- Weakness

**Social Habits**

**Tobacco Use**

Cigarettes:  Never  Quit: Date: \_\_\_\_\_ Current Smoker: Packs/day \_\_\_\_\_ # of years \_\_\_\_\_  
 Other Tobacco:  Pipe  Cigar  Snuff  Chew  
 Are you interested in quitting?  No  Yes

**Alcohol Use**

Do you drink alcohol?  No  Yes - Number of drinks/week \_\_\_\_\_  
 Is your alcohol use a concern for you or others?  No  Yes

**Drug Use**

Do you use any recreational drugs?  No  Yes

**Caffeine Intake:**  None  Coffee/tea/soda \_\_\_\_\_ cups/day

**How many cups of water do you drink a day?** \_\_\_\_\_

**Past Medical History (75pmh)**

Please only check the conditions that you had in the past

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Heart attack/Heart disease  | <input type="checkbox"/> Bleeding/Bruise easily        | <input type="checkbox"/> Cancer                                 |
| <input type="checkbox"/> Irregular heart rate        | <input type="checkbox"/> Emphysema                     | <input type="checkbox"/> Stroke                                 |
| <input type="checkbox"/> Chest pain                  | <input type="checkbox"/> Asthma/Breathing difficulties | <input type="checkbox"/> Kidney problems                        |
| <input type="checkbox"/> High blood pressure         | <input type="checkbox"/> Thyroid problems              | <input type="checkbox"/> Epilepsy/Seizures                      |
| <input type="checkbox"/> Stomach/Intestinal problems | <input type="checkbox"/> Diabetes                      | <input type="checkbox"/> Allergy or poor tolerance to heat/cold |
| <input type="checkbox"/> Arthritis                   | <input type="checkbox"/> Depression                    | <input type="checkbox"/> Anxiety                                |
| <input type="checkbox"/> Substance abuse/Addiction   | <input type="checkbox"/> Seizures                      | <input type="checkbox"/> MRSA                                   |
| <input type="checkbox"/> Hernia                      | <input type="checkbox"/> Are you pregnant?             | <input type="checkbox"/> Osteoporosis                           |
| <input type="checkbox"/> Tested positive for HIV     | <input type="checkbox"/> Hepatitis A, B, or C          | <input type="checkbox"/> Metal Implants                         |
| <input type="checkbox"/> Allergies                   | Other: _____   |   |

**Family History**

**Has any of your immediate family had any of the following conditions?**

- Heart Attack/Heart Disease
- Irregular Heart Rate
- High Blood Pressure
- Arthritis
- Diabetes
- Stroke
- Asthma/Breathing Difficulties
- Thyroid Problems
- Cancer: (Type) \_\_\_\_\_
- Osteoporosis
- MRSA
- Other: \_\_\_\_\_

**Diagnostic Tests: (75dt)**

**Have you had an X-ray?**  Yes  No **Have you had an MRI?**  Yes  No  Other test: \_\_\_\_\_

**If yes to any of the above please provide:** Date of test: \_\_\_\_\_ Location of test: \_\_\_\_\_

**Have you fallen within the last 12 months?**  Yes  No **Did the fall result in an injury?**  Yes  No

**Occupational History (75oh)**

- Working full-time
- Working part-time
- On medical leave
- Disabled
- Retired
- Unemployed

What is your current occupation: \_\_\_\_\_

Where do you work? \_\_\_\_\_

What duties do you perform? \_\_\_\_\_

When did you last work? \_\_\_\_\_

How much do you have to lift at work? \_\_\_\_\_ lbs How long do you sit at a time at work? \_\_\_\_\_

How long do you have to stand? \_\_\_\_\_ Do you have any other work related requirements? \_\_\_\_\_

**Learning / needs related to cultural and religious beliefs, emotional barriers, desire and motivation to learn, physical or memory limitation, or barriers to communication.**

- None
- Environmental
- Perception
- Memory
- Emotional
- Financial
- Language
- Motivation

Physical limitations  Religious/cultural  Other: \_\_\_\_\_

**Home Environment Considerations**

- Single level
- Multi-level
- Apartment/Condo
- Assisted Living
- Nursing Home
- Homeless

Are steps/stairs present at home?  Yes  No If YES do you have a railing?  Yes  No

Are you?  Single  Married  Widowed  Divorced  Separated

Who do you live with?  alone  with spouse  family  care facility  other \_\_\_\_\_

Do you have a care provider?  Yes  No  Not Applicable

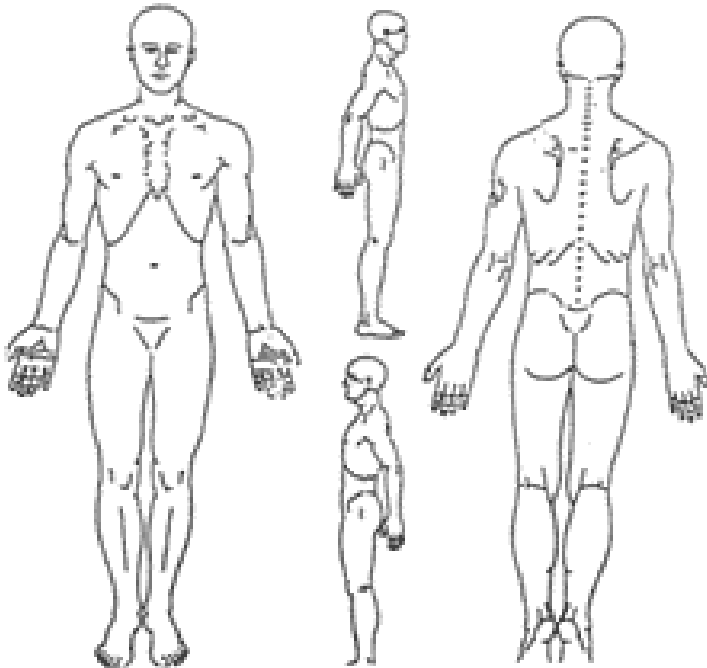
If yes, how much of the day are they available to you?  24 hrs/day  12 hrs/day  6 hrs/day  3 hrs/day  other \_\_\_\_\_

**Do you feel safe at home? (75sh)**  Yes  No

**Communication style or preferences:**  Demonstration  Printed material  Verbal instructions

**Pain**

Mark your pain locations on the diagram



**Pain Rating**

Scale used 0-10 (0=no pain, 10=emergency room pain)

Please Circle Number

**Pain at rest** 0 1 2 3 4 5 6 7 8 9 10

**Pain with activity** 0 1 2 3 4 5 6 7 8 9 10

**Description of Pain:**

- Sharp  Dull  Burning  Electrical  Cramping
- Pain is localized  Pain is radiating

**What make your pain worse?**

- Sitting  Standing  Walking  Twisting
- Bending  Squatting  Time of the day
- Running  Climbing Stairs  Physical Activity
- Weather  Lifting floor to waist
- Lifting waist to over head  Moving affected limb
- Sexual activity  Lying Down  Other: \_\_\_\_\_

**What do you do to reduce your pain?**

- Ice  Walking  Avoiding activity  Exercise/PT  Lying down
- Heat  Massage  Lose weight  Medication  Other
- Using Walker or Shopping Cart  Resting more often  Sitting More

**Does your pain affect your?**

- |                   |                              |                             |               |                              |                             |
|-------------------|------------------------------|-----------------------------|---------------|------------------------------|-----------------------------|
| Sleep             | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Appetite      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Physical activity | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Emotions      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Relationships     | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Concentration | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

**What are your current functional limitations?**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Unable to work                   | <input type="checkbox"/> Difficulty bathing              | <input type="checkbox"/> Difficulty dressing   |
| <input type="checkbox"/> Difficulty with meal preparation | <input type="checkbox"/> Unable to drive                 | <input type="checkbox"/> Unable to shop        |
| <input type="checkbox"/> Difficulty with walking          | <input type="checkbox"/> Unable to perform usual hobbies | <input type="checkbox"/> Difficulty with steps |
| <input type="checkbox"/> Difficulty with bed mobility     | <input type="checkbox"/> Reaching objects overhead       | <input type="checkbox"/> Lifting               |
| <input type="checkbox"/> Taking care of your children     | <input type="checkbox"/> Other please specify: _____     |  |

**What are your goals in coming to therapy?**

- Decrease pain  Increase range of motion  Increase strength
- Return to work  Return to previous activities  Be able to stand for \_\_\_\_\_
- Be able to sit for \_\_\_\_\_  Other: \_\_\_\_\_
- Other: \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date: \_\_\_\_\_