BreakThrough PHYSICAL THERAPY

BACKGROUND INFORMATION / MEDICAL HISTORY

To ensure you receive a complete and thorough evaluation, please provide us with the important background information on the following form. If you don't understand a question, leave the area blank and your therapist will assist you. Thank you!

PATIENT'S NAME: _____**Date:**_____ **Gender:** M F Age:_____

Are you currently: (please check one)

__Working at your usual job without restrictions. __Unable to work because of your condition. Off work since _____.

__Working at your usual job with restrictions. __Retired / Unemployed / Homemaker. __Student

What is your **primary reason** for today's appointment?:_____

Please briefly describe your symptoms :_____

_____

Onset Date: _____ Duration:_____

Have you ever seen a physical therapist for this problem? Yes No

Are you currently seeing any of the following?

__Medical Doctor (M.D.) __Psychiatrist / Psychologist __Osteopath __Physical therapist __Dentist ___Chiropractor

If you have seen any of the above during the past three months, please describe for what reason (illness, medical condition, physical, etc.): _____

_____

Past surgical history (type & date):

_____

_____

Have you EVER been diagnosed as having any of the following conditions (check all that apply)?

__Heart problems
__High blood pressure
__Emphysema / Bronchitis
__Rheumatoid arthritis
__Other arthritic problems
__Epilepsy
__Lung disease
__Hepatitis
__Stroke
__Osteoporosis
__Liver problems
Other : _____

__Circulation problems
__Asthma
__Thyroid problems
__Diabetes
__Multiple sclerosis
__Anemia
__Depression
__Tuberculosis
__Ulcers
__Blood clots
__Chest pain/angina

__Bladder/urinary tract infection
__Kidney problem/infection
__Chemical dependency
__Bone or joint infection
__Pelvic Inflammatory Disease
__Sexually Transmitted disease/HIV
__Cancer
If YES, describe what kind _____
__Past pregnancy
Delivery (circle): Vaginal Cesarian
__Current pregnancy : # of mos:____

List allergies to medications or Latex: _____

Which of the following OVER-THE-COUNTER medications have you taken in the last week?

__Aspirin
__Tylenol
__Advil / Motrin / Ibuprofen
__Laxatives
__Antacid
__Vitamins / mineral supplements
__Naproxin/Aleve
__Other:_____

Please list any PRESCRIPTION medication you are currently taking (INCLUDING pills, injections and/or skin patches):

_____

_____

How many cups of caffeinated coffee or caffeine containing beverages do you drink per day? _____

How many packs of cigarettes do you smoke a day? _____ How many days per week do you drink alcohol? _____

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During the past month, have you been feeling down, depressed, or hopeless? YES____ NO_____

During the past month, have you had little interest or pleasure in doing things? YES____ NO_____

If you answered yes to one or both of the above 2 questions, would you like help? YES____ NO_____ YES, but not today___

Have you RECENTLY noted any of the following (circle YES or NO) ?

YES	NO	Bladder irregularities	YES	NO	Nausea / vomiting
YES	NO	Fatigue	YES	NO	Numbness or tingling
YES	NO	Fever / chills / sweats	YES	NO	Falls
YES	NO	Menstrual irregularities	YES	NO	Weight loss / gain
YES	NO	Rectal bleeding			

Has anyone in your immediate family (parents, brothers, sisters) ever been treated for any of the following?

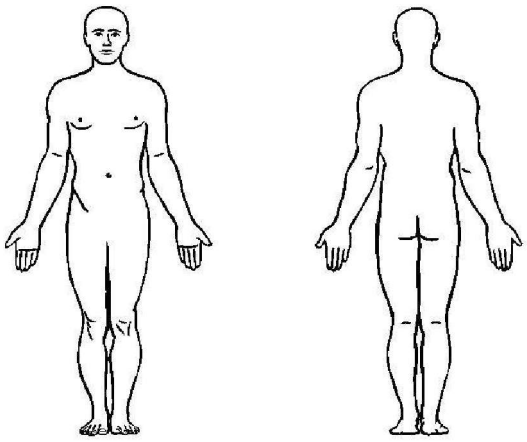
__Diabetes	__Heart disease	__Stroke
__Tuberculosis	__High blood pressure	__Cancer
__Thyroid problems	__Blood clots	__Depression
__Mental illness	__Epilepsy	

Body Chart:

Please mark the areas where you feel symptoms on the chart to the right with the following symbols to describe your symptoms:

↓ Shooting/Sharp pain ||| Numbness

○ Dull/aching pain = Tingling



On the scales below, please circle the number (0-10) which best represents the severity of your pain:

***Current level of pain*:**

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst imaginable pain

BEST for the last 48 hours:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst imaginable pain

WORST for the last 48 hours:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst imaginable pain

What is your personal goal for therapy?_____

Form reviewed with patient? __YES __NO

Therapist initials:_____