Patient Name: _____
Date: _____

Current Medical History

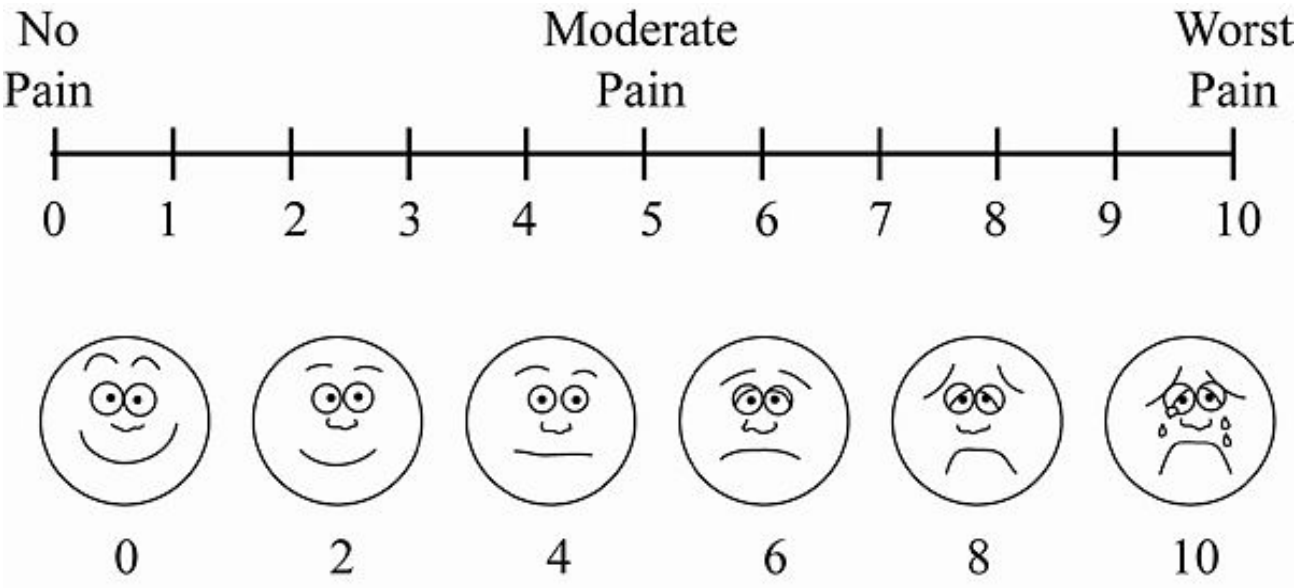
Describe the problem(s) for which you seek therapy:_____
_____

When did the current problem(s) begin? _____

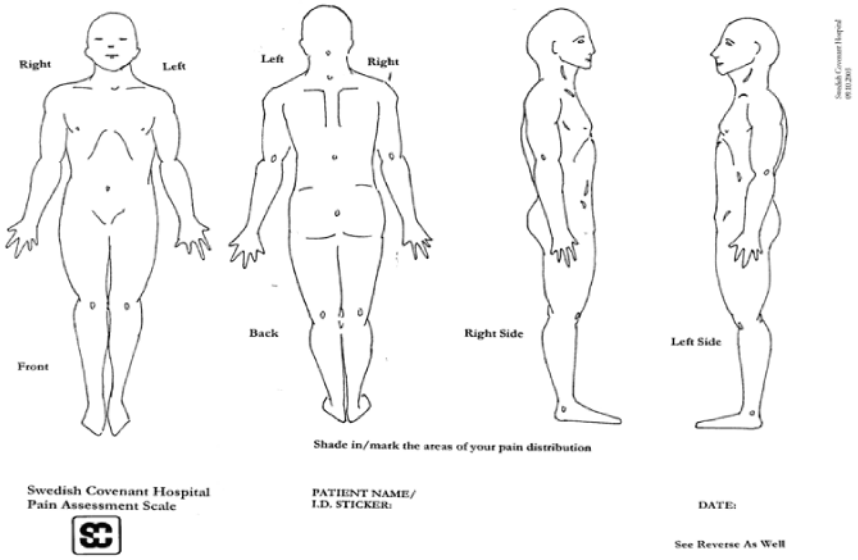
Functional limitations: (Check all that apply)

❑ Balance difficulty	❑ Flexibility limitations	❑ Shortness of breath
❑ Bending	❑ Grasping difficulty	❑ Sitting difficulty
❑ Cognition/orientation deficits	❑ Headache	❑ Sleeping difficulty
❑ Comprehension deficits	❑ Incontinence	❑ Speaking/expression difficulty
❑ Community activity limitations	❑ Joint stiffness	❑ Stair climbing difficulty
❑ Coordination deficits	❑ Joint swelling	❑ Standing difficulty
❑ Daily activity/household chore limitations	❑ Lifting/carrying difficulty	❑ Swallowing difficulty
❑ Dizziness	❑ Muscle tenderness	❑ Toileting difficulty
❑ Driving limitations	❑ Muscle weakness	❑ Transfer/bed mobility difficulty
❑ Exercise/recreation limitations	❑ Numbness	❑ Tingling
❑ Falls/history of falls	❑ Pain	❑ Walking difficulty
❑ Fatigue/poor endurance	❑ Reaching difficulty	❑ Other 1_____
	❑ Self-care difficulty	❑ Other 2_____

Please rate your pain: (circle a number)



Please shade in where you have pain on the body diagrams:



What is your goal for therapy? _____

Have you had any of the following conditions? (Check all that apply)

❑ Heart attack/MI	❑ Arthritis	❑ GERD
❑ Heart disease/surgery	❑ Broken bones/fractures	❑ Stomach problems/ulcer
❑ Pacemaker	❑ Osteoporosis	❑ Irritable bowel syndrome
❑ High cholesterol	❑ Low back pain/sciatica	❑ Multiple sclerosis
❑ High blood pressure	❑ Bowel or bladder problems	❑ Dementia
❑ Asthma	❑ Numbness and tingling	❑ Parkinson's disease
❑ COPD	❑ Headaches	❑ Psychiatric disorders
❑ Emphysema	❑ Dizziness	❑ Repeated infections
❑ Pneumonia	❑ Cancer	❑ Seizures, Epilepsy
❑ Intubation	❑ Significant weight loss	❑ Skin diseases
❑ Diabetes	❑ Infectious disease (e.g. tuberculosis, hepatitis, HIV)	❑ Allergies
❑ Peripheral neuropathy	❑ Kidney problems	❑ Thyroid problems
❑ Stroke (CVA)	❑ Liver disease	❑ Hearing impairment
❑ Slurred speech	❑ Depression	❑ Visual impairment
❑ TIA	❑ Mental illness	❑Other:_____
❑ Swallowing difficulty	❑ Eating disorder	
❑ Circulation/vascular problems	❑ Fibromyalgia	
❑ Blood clot/DVT/Pulmonary embolism	❑ Hiatal hernia	

Are you taking any medications? YES NO

Please list medications in space provided:

Medications:	**Start Date**	**Reason for taking**
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		

Surgical History

Procedure	**Date**
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	