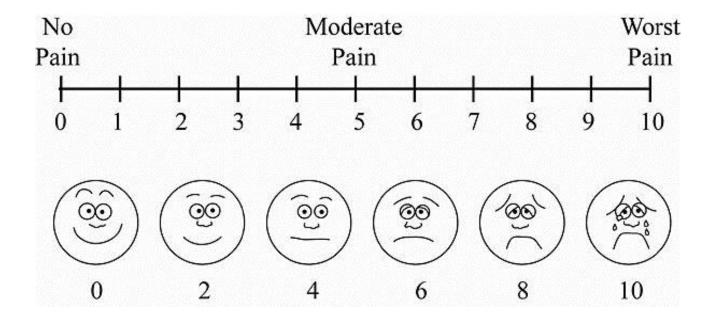
Patient Name:	 	
Date		



☐ Other 2_

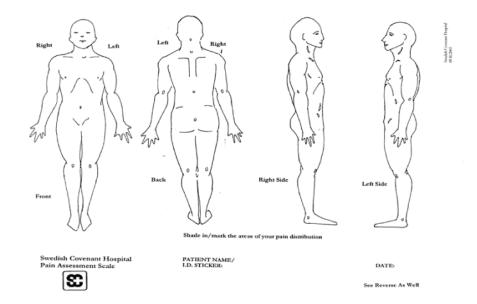
Date:		
	Current Medical Hist	tory
Describe the problem(s) for wh	nich you seek therapy:	
When did the current problem	n(s) begin?	
Functional limitations: (Check	all that apply)	
☐ Balance difficulty	☐ Flexibility limitations	☐ Shortness of breath
☐ Bending	☐ Grasping difficulty	☐ Sitting difficulty
☐ 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	☐ Lifting/carrying difficulty	☐ Swallowing difficulty
limitations	☐ Muscle tenderness	☐ Toileting difficulty
☐ Dizziness	☐ Muscle weakness	☐ Transfer/bed mobility difficulty
□ □ Driving limitations	□ Numbness	☐ Tingling
☐ Exercise/recreation limitations	☐ Pain	☐ Walking difficulty
☐ Falls/history of falls	☐ Reaching difficulty	☐ Other 1
☐ Fatigue/poor endurance	Colf core difficulty	Other 2

Please rate your pain: (circle a number)



☐ Self-care difficulty

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	
☐ Pneumonia	☐ Cancer	☐ Repeated infections
☐ Intubation	☐ Significant weight loss	☐ Seizures, Epilepsy
☐ Diabetes	☐ Infectious disease (e.g.	☐ Skin diseases
☐ Peripheral neuropathy	tuberculosis, hepatitis, HIV)	☐ Allergies
☐ Stroke (CVA)	☐ Kidney problems	☐ Thyroid problems
☐ Slurred speech	☐ Liver disease	
□ TIA	☐ Depression	☐ Hearing impairment
☐ Swallowing difficulty	☐ Mental illness	☐ Visual impairment
☐ Circulation/vascular	☐ Eating disorder	□Other:
problems	☐ Fibromyalgia	
☐ Blood clot/DVT/Pulmonary	☐ Hiatal hernia	
embolism		
l .	T .	T .

Are you taking any medications?	YES	NO
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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	