Responsive Physical Therapy, Inc.

| other: h. Do you use any special braces, supports, cushions? () yes () no Living Environment/Does your home have: a. () Stairs, no railing b. () Stairs, railing c. () Ramps d. () Elevators e. () Uneven terrain f. () Assistive devices (e.g. bathroom) | |
|---|--------------|
| With whom do you live: A () Alone Bo you use: Cane Care Pease rate your health: Pease rate your health: Pastignation opease and and many major changes during the past year: Nonetoffare | handed |
| a. () Alone a. () Cane b. () Spouse only b. () Walker or rollator c. () Cone b. () Walker or rollator c. () Other: c. () Manual wheelchair e. () Other: c. () Motorized wheelchair e. () Other: c. () Motorized wheelchair e. () Other: c. () Motorized wheelchair e. () Other: c. () Motorized wheelchair e. () Working full-time outside of home c. () Motorized wheelchair b. () Working part-time outside of home c. () Other: c. () Working part-time outside of home a. Please rate your health: c. () Working part-time from home a. Please rate your health: c. () Working part-time outside of home b. Height: d. () Working part-time outside of home b. Height: g. Does your job involve: weight : prolonged sitting, e.g. desk/computer/driving () yes () no b. Height: group out ge any special braces, supports, cushions? () electronic cigarettes # of packs per day () yes () no () cigar: pipes # per day () yes () no () cigarettes # of packs per day () yes () no () cigarettes # of packs per day () yes () no | |
| b. () Spouse only b. () Walker or rollator c. () Spouse and Family c. () Manual wheelchair d. () Other relative(s) c. () Manual wheelchair e. () Other: | |
| c. () Spouse and Family c. () Manual wheelchair d. () Other relative(s) d. () Motorized wheelchair e. () Other: | |
| d. () Other relative(s) d. () Motorized wheelchair e. () Other: | |
| e. () Other: | |
| Employment/Work (Job/School/Play a. () Working full-time outside of home b. () Working full-time from home c. () Working part-time outside of home d. () Working part-time outside of home d. () Working part-time outside of home d. () Working part-time from home e. () Homemaker () Student () Retired () Unemployed f. () Other: go cos your job involve: prolonged sitting, e.g. desk/computer/driving ()yes () no prolonged standing, e.g. equipment operator/sales ()yes () no use of small/large equipment, e.g. telephone/forklift ()yes () no use of small/large equipment, e.g. telephone/forklift ()yes () no use of small/large equipment, e.g. telephone/forklift ()yes () no use of small/large equipment, e.g. telephone/forklift ()yes () no use of small/large equipment, e.g. telephone/forklift ()yes () no tilting.bending, twisting, climbing, turning () yes () no other: () yes () no | |
| Employment/Work (Job/School/Play a. () Working full-time outside of home b. () Working part-time outside of home c. () Working part-time rom home c. () Working part-time from home c. () Working part-time from home c. () Homemaker () Student () Retired () Unemployed f. Occupation g. Does your job involve: prolonged sitting, e.g. desk/computer/driving () yes () no prolonged sitting, e.g. desk/computer/driving () yes () no use of small/large equipment, e.g. telephone/forklift () Yes () no Living Environment/Does your home have: a. () Stairs, no railing b. () Assistive devices (e.g. bathroom) General Health Status a. Please rate your health:: () Nerking part-time outside of home () Assistive devices (e.g. bathroom) General Health Status a. Please rate your health:: () Nerking part-time outside of home () Assistive devices (e.g. bathroom) General Health Status a. Please rate your health:: () Nerking part-time outside of home () Assistive devices (e.g. bathroom) General Health Status a. Please rate your health:: () Nerking part-time outside of home () Nerking part-time outside of home General Health Status a. Please rate your health:: () Nerking part-time outside of home () Nerking table tables, end of the past () yes () no () Currently smoke tobacco? () yes () no () Dervou use any special braces, supports, cushions? () Nerventerrain () Assistive devices (e.g. bathroom) | |
| a. () Working full-time outside of home General Health Status b. () Working part-time outside of home a. Please rate your health: c. () Working part-time outside of home () excellent () good () fair () poor d. () Working part-time outside of home () excellent () good () fair () poor d. () Working part-time outside of home () excellent () good () fair () poor d. () Working part-time outside of home () excellent () good () fair () poor d. () Working part-time outside of home () excellent () good () fair () poor d. () Stairs, no railing () excellent () good () fair () poor prolonged standing, e.g. desk/computer/driving () yes () no () etectronic cigarettes # of packs per day | |
| b. () Working full-time from home c. () Working part-time outside of home d. () Working part-time from home e. () Homemaker () Student () Retired () Unemployed f. Occupation | |
| c. () Working part-time outside of home d. () Working part-time from home e. () Homemaker () Student () Retired () Unemployed f. Occupation | |
| d. () Working part-time from home e. () Homemaker () Student () Retired () Unemployed f. Occupation | |
| e. () Homemaker () Student () Retired () Unemployed f. Occupation | |
| f. Occupation | |
| g. Does your job involve: Have you had any major changes during the past year. prolonged sitting, e.g. desk/computer/driving ()yes ()no new baby, job change, death in family? () yes () no prolonged walking, e.g. equipment operator/sales ()yes ()no g. Joes your job involve: new baby, job change, death in family? () yes () no prolonged standing, e.g. equipment operator/sales Social/Health Habits ()yes ()no Social/Health Habits () yes () no Yes, describe the exercise: () yes () no Yes, describe the exercise: () Stairs, railing <td< td=""><td></td></td<> | |
| <pre>prolonged sitting, e.g. desk/computer/driving () yes () no prolonged standing, e.g. equipment operator/sales () yes () no prolonged walking, e.g. equipment operator/sales () yes () no use of small/large equipment, e.g. telephone/forklift () yes () no lifting, bending, twisting, climbing, turning () yes () no exposure to gases or chemicals () yes () no other:</pre> | |
| prolonged standing, e.g. equipment operator/sales ()yes ()no Social/Health Habits prolonged walking, e.g. mail carrier, delivery service . ()yes ()no use of small/large equipment, e.g. telephone/forklift ()yes ()no . lifting, bending, twisting, climbing, turning () yes () no . exposure to gases or chemicals () yes () no . other: . . . h. Do you use any special braces, supports, cushions? . () yes () no . tiving Environment/Does your home have: . a. () Stairs, no railing . b. () Stairs, railing . c. () Stairs, railing . c. () Elevators . e. () Uneven terrain . f. () Assistive devices (e.g. bathroom) . | |
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| a. Smoking a. Smoking a. Smoking a. Smoking b. Currently smoke tobacco? () yes () no c) cigarettes # of packs per day c) stairs, no railing c) Stairs, railing c) Stairs, railing c) Namps d) () Elevators e. () Uneven terrain f. () Assistive devices (e.g. bathroom) | |
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| use of small/large equipment, e.g. telephone/forklift () cigarettes # of packs per day () yes () no () cigars/pipes # per day inting, bending, twisting, climbing, turning () yes () no () electronic cigarettes other: | |
| ()yes ()no () cigars/pipes # per day () electronic cigarettes 2. Smoked in the past? () yes Year quit 2. Smoked in the past? () yes Year quit 2. Smoked in the past? () yes Year quit b. Exercise Do you use any special braces, supports, cushions? () yes () no 2. Smoked in the past? () yes Year quit b. Exercise Do you exercise beyond normal daily activities/cho a. () Stairs, no railing b. Exercise Do you exercise beyond normal daily activities/cho a. () Stairs, no railing c. () Ramps d. () Elevators e. () Uneven terrain f. () Assistive devices (e.g. bathroom) | าด |
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| other: n. Do you use any special braces, supports, cushions? () yes () no Living Environment/Does your home have: a. () Stairs, no railing b. Exercise Do you exercise beyond normal daily activities/cho a. () Stairs, no railing b. () Stairs, railing c. () Ramps d. () Elevators e. () Uneven terrain f. () Assistive devices (e.g. bathroom) 2. How many minutes, on average per day b. No. | |
| other: h. Do you use any special braces, supports, cushions? () yes () no Living Environment/Does your home have: a. () Stairs, no railing b. () Stairs, railing c. () Ramps d. () Elevators e. () Uneven terrain f. () Assistive devices (e.g. bathroom) Living Environment (e.g. bathroom) Do you exercise beyond normal daily activities/choolea. The sercise of the exercise: Living Environment/Does your home have: a. () Stairs, no railing b. () Stairs, railing c. () Ramps d. () Elevators e. () Uneven terrain f. () Assistive devices (e.g. bathroom) Living Environment (e.g. bathroom) | () no |
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| Living Environment/Does your home have: a. Yes, describe the exercise: a. () Stairs, no railing 1. On average, how many days per week do you exercise or do physical activity? b. () Stairs, railing 2. How many minutes, on average per day b. No. b. No. | ties/chores? |
| Living Environment/Does your home have: a. () Stairs, no railing b. () Stairs, railing c. () Ramps d. () Elevators e. () Uneven terrain f. () Assistive devices (e.g. bathroom) | |
| a. () Stairs, no railing b. () Stairs, railing c. () Ramps d. () Elevators e. () Uneven terrain f. () Assistive devices (e.g. bathroom) | |
| b. () Stairs, railing exercise or do physical activity? c. () Ramps | k do you |
| c. () Ramps | - |
| d. () Elevators 2. How many minutes, on average per day e. () Uneven terrain b. No. f. () Assistive devices (e.g. bathroom) b. No. | |
| e. () Uneven terrain b. No. f. () Assistive devices (e.g. bathroom) | Jav |
| . () Assistive devices (e.g. bathroom) | |
| | |
| g. () Any Obstacles: | |
| g. () Any Obstacles: | - - |

For women only. Have you been diagnosed with:

- a. Pelvic inflammatory disease? () yes () no
- b. Endometriosis? () Yes () No
- c. Trouble with your period? () Yes () No
- d. Complicated pregnancies or deliveries? () Yes () No
- e. Pregnant, or think you might be pregnant? () Yes () No
- f. Other gynecological or obstetrical difficulties?
 - () Yes () No If yes, please describe _____

Medical/Surgical History:

- () Arthritis/gout
- () Muscular dystrophy
- () Broken bones, fractures List: _____
- () Parkinson Disease
- () Osteoporosis disease
- () Seizures/epilepsy
- () Blood disorders
- () Allergies
- () Circulation/vascular
- () Developmental or growth problems
- () Heart Problems, Liver
- () Thyroid problem
- () High blood pressure
- () Cancer
- () Lung problems
- () Infectious disease (hepatitis, tuberculosis, HIV
- () Stroke
- () Diabetes/high blood sugar
- () Kidney problems
- () Repeated infections
- () Low blood sugar
- () Ulcers/stomach problems
- () Head injury/Concussion
- () Skin diseases
- () Multiple sclerosis
- () Psycho/social disorders (Depression, Anxiety)
- () Asthma:
- () Liver Disease/Cirrhosis
- () Polio
- () Chronic Bronchitis
- () Pneumonia
- () Emphysema
- () Migraine Headaches
- () Anemia
- () Other ______

For men only. Have you been diagnosed with prostate disease? () Yes () No

Within the past year, have you had any of the following symptoms?

() Pain or a feeling of heaviness in the chest () Heart palpitation () Cough, Hoarseness () Shortness of breath () Dizziness or blackouts () Coordination problems () Sudden weakness () Problems with balance, coordination or falling () Frequent or severe headaches with no history of injury () Difficulty walking () Hearing problems, changes in hearing () Joint pain or swelling with no history of injury () Changes in vision (e.g. blurriness or loss of sight) () Persistent pain at night () Changes in hearing () Faint spells (drop attacks) () Constant pain anywhere in the body () Unusual lumps or growths () Unwarranted fatigue () Pulsating pain anywhere in the body () Constant and severe pain in lower leg or calf () Discolored or painful feet () Fever or night sweats () Frequent or severe abdominal pain () Frequent heartburn or indigestion () Change in or problems with bowel and/or bladder function () Difficulty sleeping () Nausea and vomiting () Problems with swallowing or changes in speech () Unexplained weight loss or gain () Other: Have you had surgery? 1 () Yes 2 () No If Yes, please describe and include dates: Month Year

Current Condition(s)/Chief Complaint(s)

a. Describe the problem(s) for which you are seeking physical therapy

b. When did the problem(s) begin (date)? c. What happened?

d. Have you ever had the problem(s) before? () Yes () No e. If yes, what did you do for the problem (s)? ______

f. Did the problem get better? () Yes () No g. About how long did the problem(s) last? ______

h. How are you taking care of the problem(s) now?

I. What makes the problem(s) better?

j. What makes the problem(s) worse? ______

k. What are your goals for physical therapy? ______

Are you seeing anyone else for the problem(s)? () Yes () No

Functional Status/Activity Level

- a. () Difficulty with locomotion/movement
 - () bed mobility
 - () transfers (e.g. moving from bed to chair/commode)
 - () gait (walking)
 - () on level () on ramp
 - () on stairs () on uneven terrain
- b. () Difficulty with self-care (e.g. bathing, dressing, eating)
- c. () Difficulty with home-management (e.g. household chores, shopping, driving, care of dependents)
- d. () Difficulty with community and work activities/integration
 - () work/school
 - () recreation or play activities

Medications

- a. Do you take any prescription medications? () Yes () No If yes, please list
- b. Do you take any nonprescription medications? (check all that apply)
 - () Advil/Aleve
 - () Antacids

() Aspirin

- () Ibuprofen/Naproxen
- () Herbal supplements () Tylenol

() Decongestion

- Other:
- c. Have you taken any medications previously for the condition for which you are seeing the physical therapist? () Yes () No If yes, please list:

Other Clinical Tests-Within the past year, have you had any of the following tests? (Check all that apply)

- () Angiogram () MRI
- () Arthroscopy
- () Biopsy
- () Blood tests
- () Bone scan
- () Bronchoscopy
- () CT scan
- () Doppler ultrasound
- () Echocardiogram
- () EEG
- () EKG
- () EMG
- () VNG

- () NCV (nerve conduction velocity) () Pap smear
- () Pulmonary function test
- () Spinal tap

() Mammogram

() Myelogram

- () Stool tests
 - () Stress test (e.g. treadmill, bicycle)
 - () Urine tests
 - () X-rays
 - () Other: