Responsive Physical Therapy, Inc.

Name: _____ Date: _____

Date of Birth: _____ Age: _____ Are you: ( ) Right-handed ( ) Left-handed

Outpatient Form (History and Physical)

With whom do you live:
a. ( ) Alone
b. ( ) Spouse only
c. ( ) Spouse and Family
d. ( ) Other relative(s)
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 from home
e. ( ) Homemaker ( ) Student ( ) Retired ( ) Unemployed
f. Occupation_____
g. Does your job involve:
prolonged sitting, e.g. desk/computer/driving ( )yes ( )no
prolonged standing, e.g. equipment operator/sales ( )yes ( )no
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

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) _____
g. ( ) Any Obstacles: _____

Do you use:
a. ( ) Cane
b. ( ) Walker or rollator
c. ( ) Manual wheelchair
d. ( ) Motorized wheelchair
e. ( ) Glasses, hearing aid
f. ( ) Other: _____

General Health Status
a. Please rate your health:
( ) excellent ( ) good ( ) fair ( ) poor

b. Height: _____ Weight: _____

Have you had any major changes during the past year: e.g. new baby, job change, death in family? ( ) yes ( ) no

Social/Health Habits
a. **Smoking**
1. Currently smoke tobacco? ( ) yes ( ) no
( ) cigarettes # of packs per day _____
( ) cigars/pipes # per day _____
( ) electronic cigarettes _____
2. Smoked in the past? ( ) yes Year quit_____ ( ) no

b. **Exercise**
Do you exercise beyond normal daily activities/chores?
a. Yes, describe the exercise: _____
_____
1. On average, how many days per week do you exercise or do physical activity?_____
_____
2. How many minutes, on average per day _____
b. No.

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	( ) Decongestion
( ) Antacids	( ) Herbal supplements
( ) Ibuprofen/Naproxen	( ) Tylenol
( ) Aspirin	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	( ) Mammogram
( ) Arthroscopy	( ) MRI
( ) Biopsy	( ) Myelogram
( ) Blood tests	( ) NCV (nerve conduction velocity)
( ) Bone scan	( ) Pap smear
( ) Bronchoscopy	( ) Pulmonary function test
( ) CT scan	( ) Spinal tap
( ) Doppler ultrasound	( ) Stool tests
( ) Echocardiogram	( ) Stress test (e.g. treadmill, bicycle)
( ) EEG	
( ) EKG	( ) Urine tests
( ) EMG	( ) X-rays
( ) VNG	( ) Other: _____