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| <input type="checkbox"/> ABMC | <input type="checkbox"/> ALMC | <input type="checkbox"/> AMCO | <input type="checkbox"/> APH | <input type="checkbox"/> AUWAMG |
| <input type="checkbox"/> AHCM-AS | <input type="checkbox"/> AMCG | <input type="checkbox"/> AMCS | <input type="checkbox"/> ASMMC | <input type="checkbox"/> AMG (site) |
| <input type="checkbox"/> AHCM-SL | <input type="checkbox"/> AMCK | <input type="checkbox"/> AMCWC | <input type="checkbox"/> AWAMC | |
| <input type="checkbox"/> AHCM-SS | <input type="checkbox"/> AMCMC | <input type="checkbox"/> AMHB | | |

Date: _____

What is your current work status? Full-Time Part-time

Restricted Duty Off duty due to injury Retired Not currently employed

Occupation: _____

Patient Label

1. **What problem brings you to therapy today?** _____

2. **When and how did this problem start?** _____

3. **What activities could you perform prior to this current problem you are restricted in now?** _____

4. **What treatment (medication, surgery, chiropractor, therapy, etc.) have you had for this problem?** _____

5. **What diagnostic tests have you had for this problem (X-ray, MRI, EMG, etc.)?** _____

6. Please list all medications you are currently taking. Include herbs, vitamins, etc. _____

Medication List has been printed from electronic medical record, reviewed and updated Yes No

7. Please list any allergies you have (bee stings, latex, medication, food?): _____

Allergy List has been printed from electronic medical record, reviewed and updated Yes No

8. **Please list any other health conditions you have:** Heart Problems Diabetes Dizziness Cancer
 Pregnancy Osteoporosis Blood Pressure Breathing Problems _____

Surgeries/Hospitalizations (list): _____

9. Have you had a fall or a near fall in past 12 months Yes No How Many? _____
 Any injuries? _____ Therapist Comment: _____

10. Do you live alone? Yes No If no, with whom do you live? _____

11. Is someone coming to your house to provide care for you (either nursing or personal)? Yes No

12. Please list any activity restrictions your doctor has given you (i.e. lifting, driving): _____

13. When are you scheduled to see your doctor again? _____

14. What is your goal for therapy? _____

15. Do you feel safe at home, work and/or school? Yes No If no, would you like to talk about it? Yes No

16. If you have pain, rate your pain on a 0-10 scale and shade in the painful areas on the diagrams.

Pain Scale (circle)

0 1 2 3 4 5 6 7 8 9 10

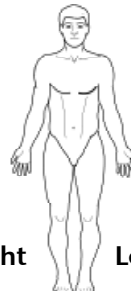
No
Pain

Extreme
Pain

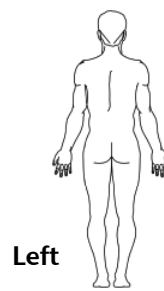
Left



Right



Left



Left

Right



Right





- ABMC ALMC AMCO APH AUWAMG
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17. Check the following activities that you have pain with or difficulty performing as a result of this current problem.

- Vigorous activities (heavy lifting, shoveling snow, mowing grass)
- Household activities (meal preparation, child care, vacuuming, laundry) _____
- Sport/Recreation activities _____
- Community activities _____
- Job-specific activities _____
- Walking: Assistive device used
 - 1 mile (12 city blocks) 6 city blocks
 - 1 city block Inside of house
- Up/down stairs
 - # of stairs to enter home _____ railings _____
 - # of stairs inside home _____ railings _____
- Bending, kneeling or squatting
- Maintaining balance
- Getting in and out of chairs
- Getting in and out of bed
- Prolonged sitting (How long? _____)
- Prolonged standing (How long? _____)
- Driving
- Sleeping
- Opening and closing doors
- Bathing or dressing yourself
 - Adaptive equipment _____
- Reaching overhead to a cabinet
- Gripping or opening a can
- Handling of small items (such as a pen or coins)
- Understanding
- Hearing
- Vision
- Reading
- Writing
- Talking
- Remembering
- Eating/swallowing
- Other: _____
- Other: _____

For Therapist to complete: Cancellation/No Show Policy reviewed

For pediatric patients: Are immunizations up to date? Yes No

Who will be receiving education? Patient Significant Other: _____

Are they ready to learn? Yes No

Preference for learning: Written Verbal Video Demonstration Other _____

Barriers to Learning:

- No barriers apparent at this time.
- States or appears to have difficulty reading
- Language Emotional Cognitive Cultural Spiritual/Religious
- Describe: _____
- Financial implications of care choices: _____
- Physical barriers to learning (e.g. blind, deaf, hard of hearing, physical handicap, pain, poor manual dexterity): _____
- Lack of family/S.O. support: _____
- Patient at increased risk for falls.

Patient/S.O. requested information on: _____

Therapist Signature: _____ Date: _____

