

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

Date: _____

Name: _____

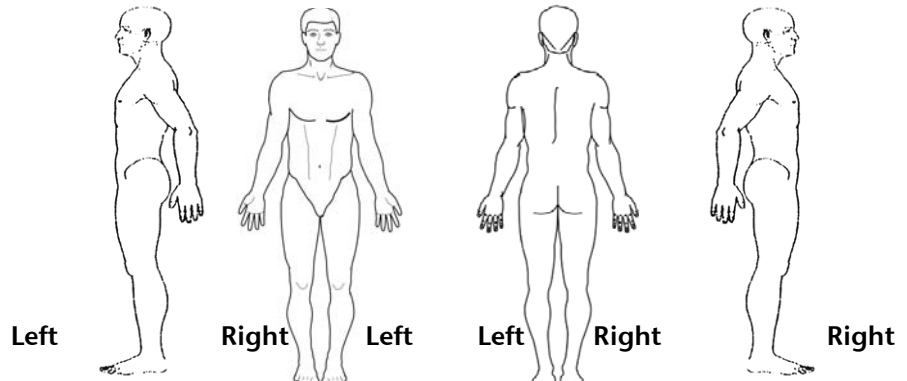
Are you presently working? No Yes Full-Time Part-time Restricted Duty Retired

Occupation: _____

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 that 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 that you are currently taking. Include herbs, vitamins, etc. _____
7. Please list any allergies that you have (bee stings, latex, medication, food?): _____
8. Please list any other health conditions you have: Heart Problems Diabetes Dizziness Cancer
 Pregnancy Osteoporosis Blood Pressure Breathing Problems Other: _____
Surgeries /Hospitalizations (please list): _____
9. Have you had a fall or a near fall in past 12 months Yes No How Many? _____
 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 that 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, shade in the painful areas on the diagram.



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17. Check the following activities that you have pain with or difficulty performing as a result of this current problem.

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

