Date: ____________________

What is your current work status?  □ Full-Time  □ Part-time
□ Restricted Duty  □ Off duty due to injury  □ Retired  □ Not currently employed

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 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
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)
  - 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:

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: ________________________________