CLIENT HISTORY

Today's date:
____/____/_____
First Name:

____
Last Name:

_____________________,
_____MI, Jr/Sr
Street address:
____
____
____
_______________City,
State,
Zip_______________

Date of Birth:
_____/_____/______

Sex: ☐ Male ☐ Female

Are you:
☐ Right-handed
☐ Left-handed

Race:
☐ Asian
☐ Native Hawaiian/Pacific Islander
☐ Black
☐ White

Ethnicity:
☐ Hispanic or Latino
☐ Not Hispanic or Latino

Language:

☐ English understood?
☐ Interpreter needed?
☐ Language spoken:
____
____

Education:
Highest grade completed:
1 2 3 4 5 6 7 8 9 10 11 12
☐ Some college/technical school
☐ College graduate
☐ Graduate school/advanced degree

SOCIAL HISTORY
Cultural/Religious:
Any customs or religious beliefs or wishes that may affect care?
____
____
____

____
____
With whom do you live?
____
____
____
Have you completed an advanced directive?
☐ Yes ☐ No
Who referred you to our practice?
____
____
____
____
Employment/Work (Job/School/Play)
☐ Working full-time
☐ Working part-time outside of home outside of home
☐ Working full-time
☐ Working part-time from home from home
☐ Homemaker
☐ Student
☐ Retired
☐ Unemployment
Occupation:
____
____

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LIVING ENVIRONMENT

Does your home have:

☐ Stairs, no railing

☐ Stairs, railing

☐ Ramps

☐ Elevator

☐ Uneven terrain

Do you use:

☐ Cane

☐ Walker or rollator

☐ Manual wheelchair

☐ Motorized wheelchair

☐ Glasses, hearing aids

☐ Assistive devices

☐ Other: ____________

Where do you live?

☐ Private home

☐ Private apartment

☐ Rented room

☐ Assisted living

☐ Nursing home

☐ Board and care

GENERAL HEALTH STATUS

Please rate your overall health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Have you had any major life changes within the past year? ☐ Yes ☐ No

SOCIAL/HEALTH HABITS

Smoking Currently smoke tobacco?

☐ Yes ☐ No ☐

Cigarettes:

Of packs/day _____

☐ Cigars/Pipes:

Per day _____

Smoked in past? ☐ Yes

Year quit: ______ ☐ No

Alcohol

How many days per week do you drink beer, wine, or other alcoholic beverages, on average?

____

How many drinks do you have, on an average day? ____

Exercise Do you exercise beyond normal daily activities and chores?

☐ Yes

Describe the exercise:

____

How many days per week? ______

How many minutes per day? ______

☐ No

FAMILY HISTORY

(Check all that apply)

☐ heart disease

☐ Hypertension

☐ Stroke

☐ Diabetes

☐ Cancer

☐ Psychological

☐ Arthritis

☐ Osteoporosis

☐ Other:

____

Please indicate relationship and age of onset if known:

____

____

____

____

MEDICAL SURGICAL HISTORY

Please check if you have ever had:

☐ Arthritis ☐ Multiple sclerosis ☐ Fractures

☐ Muscular dystrophy

☐ Osteoporosis

☐ Seizures/epilepsy

☐ Blood disorders

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☐ Parkinson disease
☐ Circulation problems
☐ Developmental problems
☐ Heart problems
☐ Thyroid problems
☐ High blood pressure
☐ Cancer
☐ Lung problems
☐ Infectious disease
☐ Stroke ☐ Kidney problems ☐ Diabetes
☐ Repeated infections
☐ Hypoglycemia
☐ Ulcers ☐ Head injury
☐ Skin diseases ☐ Depression
☐ Other:

____

Within the past year, have you had any of the following symptoms? (Check all that apply)
☐ Chest pain
☐ Difficulty sleeping
☐ Heart palpitations
☐ Loss of appetite
☐ Cough
☐ Nausea/vomiting
☐ Hoarseness
☐ Difficulty swallowing
☐ Shortness of breath
☐ Bowel problems
☐ Dizziness or blackouts
☐ Weight loss/gain
☐ Coordination problems
☐ Urinary problems
☐ Weakness in arms/legs
☐ Fever/chills/sweats
☐ Loss of balance
☐ Headaches
☐ Difficulty walking
☐ Hearing problems
☐ Joint pain/swelling
☐ Vision problems
☐ Pain at night
☐ Other:

____

Have you ever had surgery? ☐ Yes ☐ No
If yes, please describe and include dates:

____
____
____
____
____
____
____

For men only:
Have you been diagnosed with prostate disease? ☐ Yes ☐ No

For women only:
Have you been diagnosed with: Pelvic inflammatory disease?
☐ Yes ☐ No
Endometriosis?
☐ Yes ☐ No
Trouble with your period? ☐ Yes ☐ No
Complicated pregnancies/deliveries?
☐ Yes ☐ No Pregnant?
☐ Yes ☐ No
Other Ob-gyn difficulties?
☐ Yes ☐ No Please list:

____
____

CURRENT CONDITION(S)/CHIEF COMPLAINT(S)
Describe the problem(s) for which you seek physical therapy:

____
____
____
____

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When did the problem(s) begin (date)?

____

What happened?

____

____

Have you ever had the problem(s) before?

☐ Yes

What did you do?

____

____

Did it get better?

☐ Yes ☐ No

How long did it last?

____

How are you taking care of the problem now?

____

____

What are your goals for physical therapy?

____

____

Are you seeing anyone else for the problem(s)?

☐ Yes Please indicate which health care professional:

____

☐ No

FUNCTIONAL STATUS/ACTIVITY LEVEL

(Check all that apply)

☐ Difficulty with locomotion/movement

☐ Difficulty with self-care

☐ Difficulty with home management

☐ Difficulty with community and work activities

MEDICATIONS

Do you take any prescription medication?

☐ Yes ☐ No

Please list:

____

____

____

____

Do you take any nonprescription medication? ☐ Yes ☐ No

Please list:

____

____

____

____

Do you take any medication for the condition for which you are seeing the physical therapist? ☐ Yes ☐ No

Please list:

____

____

____

____

OTHER CLINICAL TESTS Within the past year, have you had any diagnostic testing done?

☐ Yes ☐ No

Please list:

____

____

____

____