PATIENT HEALTH SCREEN

AUSTIN PHYSICAL THERAPY

Patient Name _____ **Date**:_____**Age**_____

First Middle Last

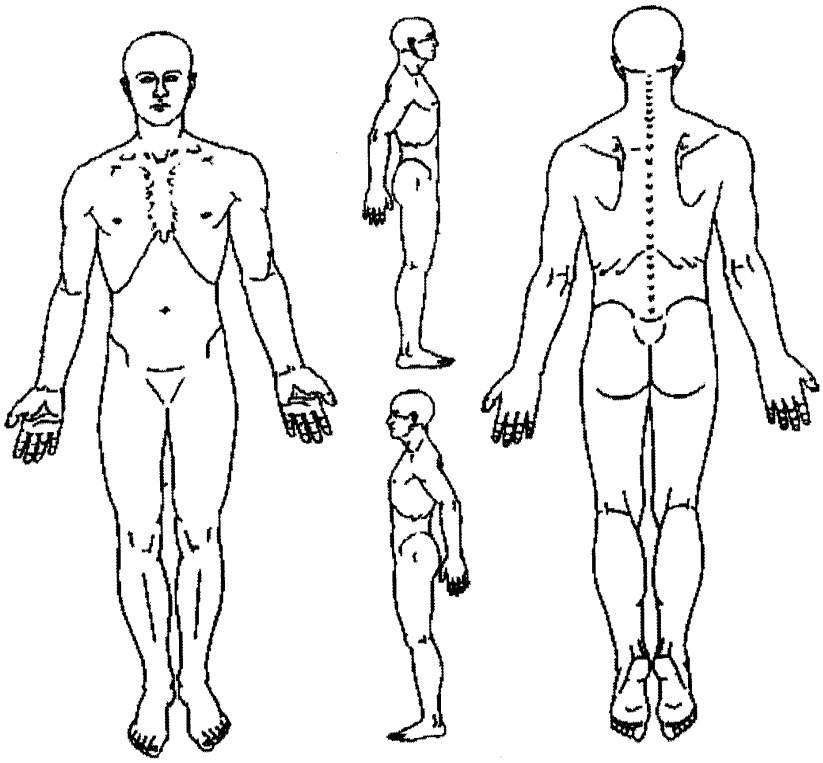
What problem are you being treated for today: _____

When did your problem begin? _____ _____

Who is your General Practitioner? _____

When is your next appt. with your GP/Referring Physician? _____ _____

Please mark the areas where you are having pain in the diagram below:



Circle your pain level AT REST

0 1 2 3 4 5 6 7 8 9 10

0= No Pain 10= Excruciating Pain

Circle your pain level WITH ACTIVITY

0 1 2 3 4 5 6 7 8 9 10

0= No Pain 10= Excruciating Pain

I am currently: ❑ **Employed** ❑ **Employed with restrictions** ❑ **On medical leave** ❑ **Not employed** ❑ **Retired**

Type of work: _____

Do you exercise? ❑ **Yes** ❑ **No** **Type** _____ **Times per week** ____

Hobbies/Sports: _____

Do you smoke? ❑ **Yes** ❑ **No** **Packs per day** _____

CHECK *(√) any conditions that you have experienced in the Past* ***CIRCLE*** *(◯)any conditions that you have Currently.*

❑Heart Problems	❑Mouth numbness	❑Blood Clots
❑**Pacemaker/implanted stimulator**	❑Difficulty Swallowing	❑Liver Disease
❑Fainting or Dizziness	❑A wound that does not heal	❑Weakness or fatigue
❑Shortness of Breath/Asthma	❑ skin condition	❑Hernias
❑Calf pain with exercise	❑Lung disease/problems	❑Blurred vision
❑Severe Headaches	❑Arthritis	❑Stomach pain or Ulcer
❑Head trauma/concussion	❑Circulatory problems	❑Back or neck injuries
❑Irregular Heartbeat	❑Muscular Weakness	❑Joint dislocation
❑Swollen and painful joints	❑Muscular pain with activity	❑Broken/fractured bones
❑Pregnancy (vaginal/c-section)	❑Cancer: _____	❑Difficulty sleeping
❑Bowel/Bladder problems	❑Lupus	❑High Blood Pressure
❑Pain with cough or sneeze	❑Diabetes: Type: _____	❑Epilepsy/Seizures/Convulsions
❑Stroke	❑Balance problems	❑Nervous or emotional problems
❑Swollen ankles or legs	❑Constant pain unrelieved with rest	❑Night pain while sleeping
❑Frequent falls	❑Tremors	❑Unexplained weight loss
❑Chest pain or pressure at rest	❑Jaw pain/TMJ	❑**Any infectious disease (TB,AIDS,Hepatitis)**

If you checked or circled any of the above, please explain:

_____

_____

❑ Tingling, Numbness, Loss of feeling? If yes, where? _____

❑ Allergies – type(s):_____

❑ Past Surgery – type(s): _____

Are you taking any medications: ❑ Yes ❑ No If yes, please list:

_____

_____

Are you allergic to Latex? ❑ Yes ❑ No

Have you had any prior treatments for your current condition (check all that apply)?

❑Hospitalization	❑Bracing/Taping/Casting	❑Physical Therapy
❑Surgery	❑TENS/Stimulation Unit	❑Injections
❑Chiropractics	❑Acupuncture	Other: _____

What is the goal you would like to achieve from Therapy?

_____

Will you be able take the time to perform the critical home exercises prescribed? ❑ Yes ❑ No

Thank You for filling out this form completely and accurately, the information helps us provide you with a level of care that meets all your needs.

Patient Signature:_____Date:_____