AUSTIN
PHYSICAL THERAPY

PATIENT HEALTH SCREEN

Patient Name _____ Date: _____/_____/_____ Age_____

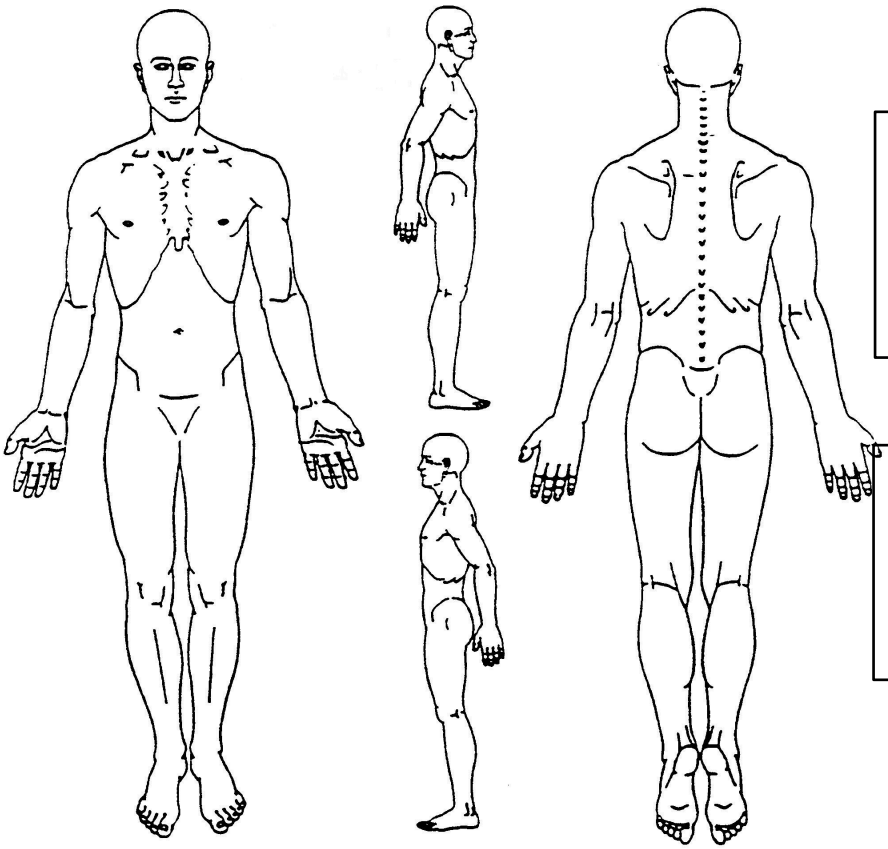
What problem are you being treated for today: _____

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 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

What makes the pain worse?_____

What makes the pain better?:_____

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

❑ Allergies – type(s):_____ **Are you allergic to Latex?** ❑ Yes ❑ NO

❑ Past Surgery – type(s): _____

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

_____

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

❑ Hospitalization ❑ Bracing/Taping/Casting ❑ Physical Therapy (if yes, where?)_____

❑ Surgery ❑ TENS/Stimulation Unit ❑ Injections

❑ Chiropractics ❑ Acupuncture Other: _____

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✓ **CHECK** any conditions that you have experiences in the ***PAST*** ○ **CIRCLE** any conditions that you have ***CURRENTLY***

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

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

_____

_____

GETTING TO KNOW YOU

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

Type of work: _____ Do you smoke? ❑ Yes ❑ No , Packs per day _____

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

Personal Trainer? ❑ Yes ❑ No, If yes, who?_____

Currently play any sports? ❑ Yes ❑ No, If yes, what?_____

Do you *compete* in any sports or activities? ❑ Yes ❑ No, If yes, what?_____

Massage Therapist? ❑ Yes ❑ No If yes, who?_____

Chiropractor? ❑ Yes ❑ No If yes, who?_____

Hobbies or other activities?: _____

Do you want to return to any activities *you use to do*? ❑ Yes ❑ No, If yes, what?_____

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.

⬇PLEASE SIGN & DATE BELOW

_____ _____

Patients Signature Date