re-form
THE SELF CARE EXPERIENCE

PHYSICAL THERAPY NEW PATIENT

Name: _____
Date: _____
DOB: _____

Date of Onset: _____

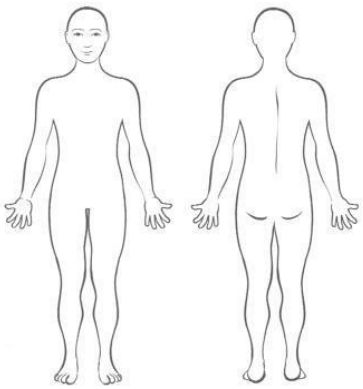
Please describe your Primary Complaint(s)

_____

_____

BODY DIAGRAM

Instructions: On the body diagram below, please indicate where your symptoms are located at the present time. Please do not indicate symptoms that are not related to your present injury or condition.



PAIN SCALE
0=No pain
1=Mild Pain: you are aware of it but it doesn't bother you
2=Mild Pain: you become more aware of it, but only begins to bother you.
3= Moderate Pain that you can tolerate without medicine
4=More severe pain that requires medication to tolerate
5=Severe Pain: you begin to feel antisocial
6=Severe Pain: you cannot participate in recreational activities
7= Very Severe Pain: you cannot leave the house
8= Intensely Severe Pain: you cannot get out of bed
9=Extremely Severe Pain: you cannot get out of bed
10=Most Severe Pain: you may feel like you need to go to the ER

Using the scale above what is your pain intensity
At best (0-10)? _____At worst? _____

What is the frequency of your pain? (check all that apply)
- ☐ Constant
- ☐ Occasional (less than daily)
- ☐ Intermittent/daily
- ☐ Sporadic (less than weekly)

How would you describe the quality of your pain?
- ☐ Dull
- ☐ Steady
- ☐ Sharp
- ☐ Throbbing
- ☐ Burning

Did your symptoms come on: (Please check which applies)
- ☐ Gradual?
- ☐ Sudden?

Was the onset of your symptoms due to any of the following? (check all that apply)
- ☐ Injury at home
- ☐ Sports
- ☐ Chronic symptoms
- ☐ Recreational Activity
- ☐ Gradual Onset
- ☐ Trauma
- ☐ MVA
- ☐ Unknown
- ☐ Work-related
- ☐ Repetitive Motion
- ☐ Other_____

Over the past two weeks are your symptoms: (Please check which applies)
- ☐ Improving
- ☐ Unchanged
- ☐ Worsening

Have you undergone any of the following diagnostic testing?
- ☐ X-rays
- ☐ CT Scan
- ☐ MRI
- ☐ Blood Test
- ☐ Bone Scan
- ☐ Doppler Studies
- ☐ Urinalysis
- ☐ Nerve conduction, EMG
- ☐ Cardiac Stress Test
- ☐ Mammogram

Results from above tests: _____
When is your Next Physician Visit? _____

Do you experience numbness or pins and needles?
☐ Yes ☐ No If yes, please indicate location _____
If yes, how often?
- ☐ Constant
- ☐ Occasional (less than daily)
- ☐ Intermittent/daily
- ☐ Sporadic (less than weekly)

In the past year have you experienced any of the following? (check all that apply)
- ☐ Nausea
- ☐ Soreness with Exercise
- ☐ Loss of balance
- ☐ Difficulty Swallowing
- ☐ Shortness of Breath
- ☐ Unexpected weight loss or gain
- ☐ Night pain
- ☐ Dizziness/Vertigo
- ☐ Difficulty walking
- ☐ Loss of Balance
- ☐ Drop Attacks
- ☐ Pain at Night
- ☐ Coordination Problems
- ☐ Hoarseness of Voice
- ☐ Loss of Appetite
- ☐ Bowel/Bladder Control Problems
- ☐ Ringing in the ears
- ☐ Fever (recent)
- ☐ Fatigue
- ☐ Unexplained weight loss or gain

FOR WOMEN ONLY:

Have you ever been diagnosed with:

Pelvic Inflammatory Disease? ☐ Yes ☐ No

Endometriosis? ☐ Yes ☐ No

Trouble with your period? ☐ Yes ☐ No

Complicated pregnancies or deliveries? ☐ Yes ☐ No

Pregnant or think you might be pregnant? ☐ Yes ☐ No

Other gynecological or obstetrical difficulties? ☐ Yes ☐ No

If yes:_____

FUNCTIONAL LEVEL AT PRESENT

(Do any of the following activities provoke your symptoms)

- ☐ Arm/hand Activities
- ☐ Ascending Stairs
- ☐ Bending
- ☐ Dressing
- ☐ House Cleaning
- ☐ Computer Use
- ☐ Twisting
- ☐ Descending Stairs
- ☐ Kneeling
- ☐ Lying on Left Side
- ☐ Lying on Right Side
- ☐ Lying on Stomach
- ☐ Running
- ☐ Lying on Back
- ☐ Overhead
- ☐ Driving
- ☐ Cooking
- ☐ Toileting
- ☐ Work Activities
- ☐ Sitting
- ☐ Reaching
- ☐ Squatting
- ☐ Standing
- ☐ Walking
- ☐ Walking on un-level surfaces

PREVIOUS FUNCTIONAL LEVEL

For functional limitations described above, what was your ability prior to your injury/illness?

_____

_____

_____

_____

_____

_____

_____

PRIOR EPISODES

Have you had prior episodes of this condition? ☐ Yes ☐ No

If yes, how many prior episodes? ☐ 1 ☐ 2-3 ☐ 3-4 ☐ 4 or more ☐10 or more

When did they occur? _____

How often? ☐ Weekly ☐ Monthly ☐ Yearly ☐ Other_____

Is the severity ☐ Increasing ☐ Decreasing ☐ Unchanged

Which treatments have you had for THIS condition?

- ☐ Massage Therapy
- ☐ Time off work
- ☐ Chiropractic Treatment
- ☐ Injection
- ☐ Surgery
- ☐ None
- ☐ Physical Therapy
- ☐ Occupational Therapy
- ☐ Bed Rest
- ☐ Acupuncture
- ☐ Medication
- ☐ Other _____

MEDICAL HISTORY

How would you describe your general health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

_____

Please check if you have ever been diagnosed with any of the following:

- ☐ Anemia
- ☐ Allergies
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Cancer
- ☐ Congenital Heart Defect
- ☐ Depression
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy/Seizures
- ☐ Sciatica
- ☐ Tuberculosis (TB)
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart Disease
- ☐ Heart Attack
- ☐ Headaches
- ☐ Hemophilia
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Leukemia
- ☐ Liver Disease/Problem
- ☐ Loss of Consciousness
- ☐ Metal Implant
- ☐ Osteoarthritis (OA)
- ☐ Osteoporosis
- ☐ Osteopenia
- ☐ Pacemaker
- ☐ Peripheral Vascular Disease
- ☐ Prostate Problems
- ☐ Rheumatoid Arthritis (RA)
- ☐ Scoliosis
- ☐ Sickle Cell Disease
- ☐ Stroke
- ☐ Suicidal Thoughts
- ☐ Thyroid Problems
- ☐ Insomnia
- ☐ Hepatitis
- ☐ Lupus
- ☐ Kidney Infections
- ☐ Low Blood Pressure
- ☐ Other_____

Have you ever experienced any other musculoskeletal injuries?

If yes, please describe?_____

_____

_____

LIFESTYLE

What is your occupation?_____

Are you… ☐ Right hand Dominant ☐ Left Hand Dominant

D**o you smoke cigarettes?** ☐ Yes ☐ No

If yes, _____ packs per day x _____ years?

Do you drink alcohol? ☐ Yes ☐ No

How many drinks per week? _____

Do you drink caffeinated beverages? ☐ Yes ☐ No

How many cups (8 oz.) per day? _____

Are you generally (check box)

☐ Sedentary ☐ Physically Active

What do you enjoy for physical activity

- ☐ Home ☐ Gym ☐ Free Weights
- ☐ Machines ☐ Elliptical Trainer ☐ Treadmill
- ☐ Stationary Bike ☐ Bike ☐ Pool
- ☐ Exercise Classes ☐ Pilates ☐ Yoga
- ☐ Other_____