Patient Information Sheet

Name: ____ **Age**: ______________

Date of onset (Injury/Problem/Surgery): _______________________________

Have you had previous treatment for the condition you are here for today: **Yes ___** **No ___**

If yes, what? ____

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Condition	Yes	No	Condition	Yes	No
Diabetes			Seizures		
High Blood Pressure			Dizziness		
Cardiac Arrhythmias			Stroke		
Heart Attack			Aortic Aneurysm		
Pacemaker			Double Vision		
Chronic Headaches/Migraines			Cancer		
Kidney Problems			Pregnant		
Nervous problems/Anxiety			Recent Weight Loss/Gain		
Pins & Needles/Numbness			Circulatory Disease		
Neurological Disease (MS, Parkinson's, etc.)			Asthma		
Arthritis (OA, DJD, RA)			Thyroid Dysfunction		
Latex or Tape Allergy			Blood disorders (Hepatitis, HIV, etc.)		
Incontinence			Osteoporosis		
Current Bed Bug Infestation					
Other:			If yes, explain:		

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Surgical History:____

____

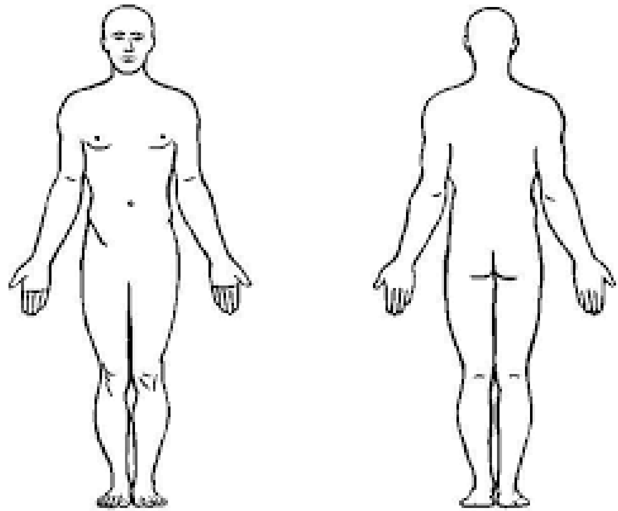
Medications:____

____

What day to day problems do you encounter that are related to the problem you are here for today?

____

Please circle the part(s) if the body diagram where you are having pain:



Please circle your level of pain using a 0-10 scale:
0= No pain 10= Emergency room level

How do you rate your quality of life?

Excellent __ Good __ Fair __ Poor __

Have you had any falls in the past year?

Yes __ How many? ____ No __

Check all that apply:
I use a **cane __ walker/rollator __ wheelchair __ ankle brace __ knee brace __**

Please check all that apply:

I live **alone __ with a spouse/partner/significant other __ with a child/children __ with a relative __ with a friend/roommate __ with a personal care attendant __ in a group setting __**
in a private home __ in a private apartment __ in a rented room __ in an assisted living facility __
receiving hospice care __

Occupation:___________________________________

Are you disabled? Yes ___ How? ____ **No** __

Is there anything else that you would like your Physical Therapist to be aware of that is related to your current issue?

____