**Big Sky Physical Therapy**

*To insure you receive a complete and thorough evaluation, please provide us with important background information on the following form. If you do not understand the question, your therapist will assist you. Thank you.*

#  HISTORY OF PRESENT CONDITION

1. What are your symptoms?

Localize areas of **pain** or **abnormal** sensation on the body chart below (Shade in where appropriate)

FRONT BACK

1. When did your symptoms begin?

(Please indicate a specific date if possible)

On a scale from 1-10 please indicate your level of pain?

(0 being“no pain” and 10 being“worst pain imaginable”)

1. Was the **onset** of this episode gradual or sudden? (check one)

n gradual n sudden

1. Which of the following **best describes** how your injury occurred?

(if your condition is post-surgical please indicate as per original injury)

n lifting n a blow to the face

n a MVA (car accident) n being hit by a ball

n a fall n a dental appointment

n overuse (cumulative trauma) n throwing

n trauma n an incident at work

n degenerative process n unknown

n during recreation/sports n other

n running

1. Since onset, are your symptoms getting: (check one)

n better n worse n not changing

1. Have you had similar symptoms in the past?

n Yes n No More than one episode? n Yes n No

1. Nature of pain/symptoms (check all that apply)

n sharp n aching n constant

n dull n periodic n other

n throbbing n occasional

1. As the day progresses, so your symptoms: (check one)

n increase n decrease n stay the same

**PATIENT QUESTIONNAIRE**

**Name: Date: Age: Weight: Height:**

1. Does the pain wake you at night? n No n Yes if “*yes*”, is it present n while lying still

n only when changing positions

n both

1. Do you have pain/stiffness upon getting out of bed in the morning?

n Yes n No

1. In what position do you sleep? (check all that apply)

n right side n back n other

n left side n chair/recliner

n stomach n back, sides, stomach

1. Since the onset of your current symptoms have you had: n any difficulty with control of bowel or bladder function n fever/chills

n any numbness in the genital or anal area

n numbness

n any dizziness or fainting attacks

n weakness

n unexplained weight change

n night pain/sweats

n malaise (vague feeling of bodily discomfort)

n problems with vision/hearing

n none of the above

1. What aggravates your symptoms? (check all that apply)

|  |  |  |  |
| --- | --- | --- | --- |
| n | sitting | n | repetitive activities |
| n | going to/rising from sitting | n | lying down |
| n | household activities | n | walking |
| n | up/down stairs | n | standing |
| n | reaching overhead | n | squatting |
| n | reaching in front of body | n | sleeping |
| n | reaching behind back | n | coughing/sneezing |
| n | reaching across body | n | taking a deep breath |
| n | talking, chewing, | n | looking up overhead |
|  | yawning, all (circle one) | n | swallowing |
| n | recreation/sports including | n | stress |
|  |   | n | sustained bending |
|  |   | n | other  |

1. What relieves your symptoms? (check all that apply)

n sitting n rest n massage

n heat n standing n medication

n cold n walking n nothing

n stretching n exercise n other

n wearing a splint/orthosis n lying down

1. Have you had any previous treatment for this condition? (check all that apply)

n none n physical therapy

n medication (oral) n hypnosis

n joint manipulation n biofeedback

n exercise n TENS unit

n massage therapy n acupuncture

n traction n bed rest

n bracing/taping n overnight hospitalization

n injection into spine n casting

n injection into skin/muscles n other

1. Have you had any of the following tests?

n none n Arthrogram n TENS unit

n x-rays n biofeedback n Vestibular

n CT Scan n Bone Scan n other n MRI n Stress x-ray Test Results:

#  MEDICATION

Please list any prescription medications you are currently taking

*(pain pills, injections and/or skin patches, etc.)*:

Prescribing MD: Phone: Are you currently taking any of the following over the counter medications?

n aspirin n vitamins/mineral supplements

n Tylenol n Advil/Motrin/ibuprofen

n corticosteroids n other

n antihistamines

#  PREVIOUS FUNCTIONAL LEVEL

n **Independent in all activities**

(work, community, home, recreation)

# Self-care

n Independent in all self-care activities (bathing, toileting, dressing, etc.)

n Difficulty performing self-care activities n Need assistance with self-care activities n Difficulty performing household chores **Social**

n Need assistance with activities in community outside of home

# Hobbies:

 **CURRENT FUNCTIONAL LEVEL**

n **Independent in all activities**

(work, community, home, recreation)

# Self-care

n Independent in all self-care activities (bathing, toileting, dressing, etc.)

n Difficulty performing self-care activities n Need assistance with self-care activities n Difficulty performing household chores **Social**

n Need assistance with activities in community outside of home

# Hobbies:

 **WORK HISTORY**

**Occupation**

n employed full-time n student

n employed part-time n retired

n self employed n unemployed

n homemaker n other

**Physical activities at work** (check all that apply)

n sitting n computer use

n standing n heavy equip. operation

n phone use n driving

n repetitive lifting n other

n heavy lifting

Are you currently receiving or seeking disability for this condition?

n Yes n No

If not performing your normal activities at work do you plan to RETURN to your previous activity level?

n Yes n No

#  LIVING SITUATION

n live alone n home/apartment

n live with family members n assisted living complex

n live with caregiver n other

n retirement complex

# Setting:

n stairs (railing) n no stairs n uneven ground

n stairs (no railing) n ramp n elevator

n other

#  GENERAL HEALTH

How would you rate your average health?

n Excellent n Average n Poor

n Good n Fair

Do you use exercise outside of normal daily activities? n 5+ days/wk n 1-2 days/wk n zero n 3-4 days/wk n occasionally

Recreation activities consisting of:

n running n golfing n walking

n biking n tennis n skiing

n swimming n other

Do you drink caffeinated beverages?

n No n Yes How many/much per day

Do you smoke?

n No n Yes Packs of cigarettes per day

What is your stress level?

n Low n Medium n High

Are you seeing any health care providers other than the physical therapist for this current condition? (please list)

#  PAST MEDICAL HISTORY

Have you ever had/been diagnosed with any of the following condition? (check all that apply)

n Cancer (type) n Heart problems

n Depression n High blood pressure

n Stroke n Lung problems

n Kidney problems n Blood disorders

n Thyroid problems n Epilepsy/seizures

n Diabetes n Allergies

n Multiple sclerosis n Rheumatoid arthritis

n Arthritis n Osteoporosis

n Head injury n Broken bone

n Stomach problems n Circulation/vascular problems n Parkinson’s disease n other n Infectious disease

(i.e. Hepatitis, Tuberculosis, etc.)

Please list any past surgeries related to you current problem:

**SURGERY DATE**

#  FAMILY HISTORY

Has anyone in your immediate family (parents, brothers, sisters) ever been treated for the following?

n Diabetes n Cancer

n Heart disease n Arthritis

n High blood pressure n Osteoporosis

n Stroke n Psychological condition

n Other