Simple to BE
HOLISTIC PHYSICAL THERAPY

PATIENT INFORMATION:

Name:_____ Date of Birth:_____
Name of Parent/Guardian if Minor: _____
Address:_____
Cell Phone:( )_____ Home Phone:( )_____
Email:_____ Hobbies/Occupation_____
Emergency Contact: _____ Phone:( ) _____
Referring Doctor: _____ Phone:( ) _____

WHAT ARE YOUR PRIMARY CONCERNS?_____

_____

WHAT DO YOU FEEL MAY HAVE CONTRIUBUTED TO YOUR ISSUE?_____

CHECK ALL THE STATEMENTS THAT ARE TRUE:

_____Changes in my bladder or bowels function
_____Swelling in ankles/feet or hands
_____Numbness or tingling in feet/legs or hands/arms
_____Unexplainably lost or gained more than 10 pounds
_____I have had recent internal bleeding (ulcer, intestinal, etc.)
_____I have an implant (IUD, pacemaker, stent, other)
_____Eating changes my symptoms
_____Blurred vision
_____I feel dizzy
_____I wake with night pain
_____I have had a recent infection
_____I am pregnant or plan to start

List Medications you are taking, including supplements:

_____
_____
_____
_____
_____
_____

Name:_____ **DOB:**_____

MEDICAL and SURGICAL HISTORY

General
- □ Headaches / Migraines
- □ Blackouts
- □ Dizziness / Vertigo
- □ Sinus Problems
- □ History of Fall(s)
- □ Balance Disturbance
- □ Vision Loss
- □ Hearing Loss
- □ Memory Loss
- □ Insomnia

Cardiovascular / Blood
- □ High Blood Pressure
- □ Heart Attack / MI
- □ Heart Disease
- □ CHF
- □ Aneurysm
- □ Bleeding Disorder
- □ Blood Clots / DVT
- □ Anemia
- □ Chest Pain / Angina
- □ Arrhythmia
- □ High Cholesterol

Digestive
- □ IBS
- □ Crohn's Disease
- □ Celiac Disease
- □ GERD / Gastritis
- □ Ulcer _____
- □ Frequent Loose Stools
- □ Frequent Constipation
- □ Discomfort after meals
- □ Hiatal Hernia
- □ Swallowing Dysfunction
- □ Liver Disorder

Musculoskeletal / Orthopedic
- □ Osteoarthritis
- □ Fractures _____
- □ Compression Fracture
- □ Stress Fracture
- □ Dislocation
- □ Inguinal Hernia
- □ Hernia (other) _____
- □ Diastasis Recti
- □ Carpal Tunnel
- □ Thoracic Outlet Syndrome
- □ Spinal Stenosis
- □ Sciatica
- □ Spondylolisthesis
- □ Herniated Disc
- □ TMD
- □ Other Ortho Injuries

_____

Immune / Endocrine / Metabolic
- □ Diabetes Type 1 or 2 (circle)
- □ Low Blood Sugar
- □ Hepatitis A B C (circle)
- □ HIV / AIDS
- □ TB
- □ Cancer _____
- □ Thyroid Dysfunction
- □ Autoimmune Disease

_____
- □ Osteoporosis / Osteopenia
- □ Gout
- □ Rheumatoid Arthritis
- □ Lupus
- □ Fibromyalgia
- □ Inflammatory Condition

_____

Surgical History
- □ CABG / Bypass Surgery
- □ Pacemaker / Defibrillator
- □ Vascular Surgery / Stents
- □ Abdominal Surgery
- □ Gastric Bypass Surgery
- □ Hysterectomy
- □ Tubal Ligation
- □ Laparoscopy
- □ Bladder Surgery
- □ C – Section
- □ Hernia Surgery
- □ Gall Bladder Surgery
- □ Orthopedic Surgery
- □ Back / Neck Surgery
- □ Plastic Surgery
- □ Other Surgeries

_____

Urogenital / Gynecological
- □ Urological Disorder
- □ Kidney Disease

_____
- □ Incontinence
- □ Endometriosis
- □ Dysmenorrhea
- □ Gynecological Disorder
- □ Fibroids / Cysts
- □ # of childbirths _____

Respiratory
- □ Asthma
- □ Emphysema / COPD
- □ Pneumonia
- □ Allergies
- □ Sleep Apnea
- □ Deviated Septum
- □ Shortness of Breath
- □ Other Lung disorders

_____

Nervous System
- □ Head / Brain Injury
- □ Stroke / TIA
- □ MS
- □ Peripheral Neuropathy
- □ Epilepsy / Seizure Disorder
- □ Parkinson's
- □ Neuromuscular Disorder
- □ Other Neuro disorder

_____

Trauma
- □ Whiplash
- □ Motor Vehicle Accident
- □ Concussion
- □ Other Trauma

Nutritional
- □ Nutritional Deficiency
- □ Food Allergies
- □ Eating Disorder

Family History:
- □ Heart Disease
- □ High Blood Pressure
- □ Diabetes
- □ Cancer

Name:_____ **DOB:**_____

BONES/JOINTS & AREAS OF PAIN: (Circle)

Lower Back Middle back Upper back Neck Head Jaw

Abdomen Tailbone Pelvic Region Ribs Shoulders Elbows

Wrist /Hands Hips Knees Feet Plantar fasciitis Sciatica Carpal tunnel

WHAT MAKES YOUR SYMPTOMS WORSE OR WHEN ARE THEY WORSE? (Circle)

Sitting Standing Walking Getting out of bed Getting up from sitting Sleeping Work
Morning Evening House Chores Exercise or Sports Sexual intercourse Menses Other____

WHAT MAKES YOUR SYMPTOMS BETTER? (Circle)

Heating pad Ice pack Resting in bed Resting in Chair Walking Exercise Stretching Medication Other _____

WHAT TREATMENTS HAVE YOU HAD FOR THIS PROBLEM?

Physical Therapy Acupuncture Chiropractic Massage Medication Surgery None Other

Types of treatments that helped:_____

WHAT ARE YOUR GOALS OF PHYSICAL THERAPY?_____

Please circle or draw your areas of PAIN or SYMPTOMS on diagram below:

Please rate your symptoms on scale of **0 to 10** (with **0= no pain** and **10= the worst pain** imaginable/like you need to go to emergency room)

Current_____ /10

Best _____ /10

Worst _____ /10

Circle your current level of function from 1-10:

(Barely functioning) **1 2 3 4 5 6 7 8 9 10** (Full Function)