OPTM PHYSICAL THERAPY

Date: _____ Name: _____ DOB: _____ Age: _____

Occupation: _____ Work status: FT / PT / Retired / Not Working

Primary Care Physician: _____

Please bring any recent x-ray, MRIs surgical pictures, surgical report or other test results:

***Please answer as fully as possible*.**

Date symptoms began? _____

List any recent surgery: _____

What was the cause of your current problem? _____

Have you had this before? _____ What helped you? _____

What are you doing to help yourself now? _____

Did the problem come on immediately or gradually? _____

How has your problem changed over the last 14 days? _____

What makes symptoms better? _____

What makes symptoms worse? _____

How do your symptoms change over the course of the day? _____

Can you sleep through the night and how? _____

What percentage of your normal functional ability are you at now? _____

Do you normally exercise and how? _____

Please indicate pain <u>range</u> on scale

Your pain when you feel the best:

0__|__|__|__|__|__**5**__|__|__|__|__|__**10**

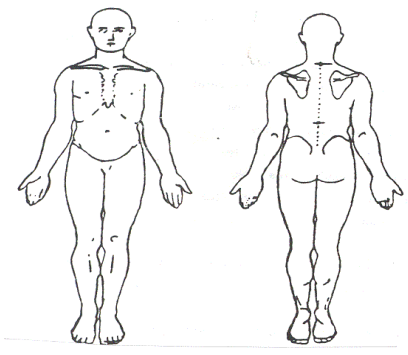
no pain **worst**

Your pain when you feel the worst:

0__|__|__|__|__|__**5**__|__|__|__|__|__**10**

no pain **worst**

Pease draw areas of symptoms on diagram



Check any of the following which you <u>cannot do</u> for <u>20 min</u> comfortably:

Sit		**Walk**		**Normal Job Duties**		**Sleep**		**House Work**	
Stand		**Drive**		**Carry 20 lbs.**		**Use Computer**		**Yard Work**	

Check any of the following you <u>cannot do</u> with your normal ability:

Climb Stairs		**Move from sit to stand**		**Get in/out of car**	
Reach overhead		**Move from floor to standing**		**Feed yourself**	
Lift 5-10 lbs. overhead		**Pick 10-20 lbs. up from floor**		**Use utensils**	
Bathe and groom self		**Move in bed**		**Chew**	
Dress yourself					

Personal Medical History – Check and describe when applicable

	Yes	No	
Current Infection			**Describe:**
Cancer			**Describe:**
Hospitilization the last year			**Describe:**
Other			**Describe:**

	Yes	No		Yes	No
Heart Problems or Pacemaker			**High Blood Pressure**		
High Cholesterol			**Cirulcation Problems**		
Asthma			**Emphysema or Bronchitis**		
Chemical Dependency			**Smoking**		
Thyroid Problems			**Diabetes**		
Multiple Sclerosis			**Rheumatoid Arthritis**		
Depression			**Other Athritic Condition**		
Tuberculosis			**Metal Implants**		
Kidney Disease			**Hepatitis**		
Epilepsy			**Stroke/TIA**		
Osteoporosis or Osteopenia			**Anemia**		
Pregnancy			**Allergies**		
Chicken Pox, Shingles or Herpes			**Hertburn or Esophogeal Reflux**		
			Bowel or Bladder problems		

Please rate the following:

	0 – Never	1 – Several Days	2 – More than 50% of the Time	3 – Every Day
I have little interest or pleasure in doing things.				
I often feel down, depressed, or hopeless.				

Have you recently noted any of the following:

	Yes	No
Weight Loss		
Nausea/Vomiting		
Fatigue		
Weakness		
Fever/Chills/Sweats		
Numbness/Tingling		

	Yes	No
Shooting pain both arm or legs		
Persistent Cough		
Dizziness		
Headaches		
Blurred Vision		
Blood in stool		

Please list all medications you are currently taking:

MEDICATION	DOSAGE	TIMES PER DAY	REASON FOR MEDICATION

Has your physician discussed your condition with you? _____

_____ _____

Signature **Date**

_____ _____

Printed Name **Relationship**