

# Patient Information

# Optimal Care Physical Therapy, P.C.

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Last First MI

Please describe your current symptoms: \_\_\_\_\_  
\_\_\_\_\_

What date did your symptoms/injury begin? \_\_\_\_\_ Surgery date: \_\_\_\_\_

**Is this a result of a motor vehicle accident?** (Yes) (No)    **Work related injury?** (Yes) (No)

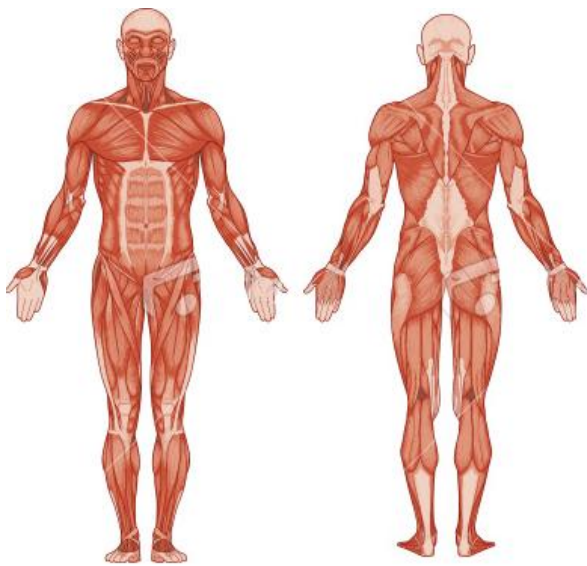
What was the initial cause of your symptoms? \_\_\_\_\_

Have you ever experienced these symptoms before? \_\_\_\_\_

What makes your symptoms worse? \_\_\_\_\_

What makes your symptoms better? \_\_\_\_\_

Please indicate on the illustration below where the symptoms/pain occurs:



Severity – At Rest										
0	1	2	3	4	5	6	7	8	9	10
(None)										(Max)

Severity – During Activity										
0	1	2	3	4	5	6	7	8	9	10
(None)										(Max)

How much do your symptoms interfere with your activities?
<input type="checkbox"/> None (1-20%) <input type="checkbox"/> Rarely (20-40%) <input type="checkbox"/> Often (40-60%) <input type="checkbox"/> Most of the time (60-80%) <input type="checkbox"/> Always (80-100%)

Are you having difficulty with any of the following?
<input type="checkbox"/> Bed Mobility <input type="checkbox"/> Transfers (ex. Chair to stand) <input type="checkbox"/> Walking <ul style="list-style-type: none"><li><input type="radio"/> On level ground</li><li><input type="radio"/> On stairs</li><li><input type="radio"/> Uneven Terrain</li></ul> <input type="checkbox"/> Self Care (ex. dressing, bathing, eating) <input type="checkbox"/> Driving <input type="checkbox"/> Household chores <input type="checkbox"/> Work/school related activity

# Medical History

Optimal Care Physical Therapy, P.C.

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Last First MI

When your last physical exam? \_\_\_\_\_ Do you smoke? Y / N

Physician's Name: \_\_\_\_\_ Have you smoked in the past? Y / N

Past hospitalizations and surgeries: \_\_\_\_\_ Do you use alcohol? Y / N How often? \_\_\_\_\_

Current medications: \_\_\_\_\_ On average, how many days a week do you exercise? \_\_\_\_\_

List any allergies (including medications) that you have: \_\_\_\_\_ How many minutes, on average, a day? \_\_\_\_\_

## Within the past year, have you had any of the following?

<input type="checkbox"/> Arthritis <input type="checkbox"/> Broken Bones/fractures <input type="checkbox"/> Head injury <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Blood disorders <input type="checkbox"/> Circulation/vascular problems <input type="checkbox"/> Heart Problems <input type="checkbox"/> High blood pressure <input type="checkbox"/> Stroke <input type="checkbox"/> Diabetes/high blood sugar <input type="checkbox"/> Low blood sugar			<input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Muscular Dystrophy <input type="checkbox"/> Parkinson's disease <input type="checkbox"/> Seizures/Epilepsy <input type="checkbox"/> Allergies <input type="checkbox"/> Developmental or growth problems <input type="checkbox"/> Thyroid problems <input type="checkbox"/> Cancer <input type="checkbox"/> Infectious disease <input type="checkbox"/> Kidney problems <input type="checkbox"/> Skin diseases		
<input type="checkbox"/> Weight Loss or Gain <input type="checkbox"/> Fevers <input type="checkbox"/> Trouble Sleeping <input type="checkbox"/> Chronic Fatigue <input type="checkbox"/> Excessive bleeding <input type="checkbox"/> Easy bruising <input type="checkbox"/> Abnormal Thirst <input type="checkbox"/> Itchy, red eyes <input type="checkbox"/> Vision problems <input type="checkbox"/> Ear pain <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Hearing loss <input type="checkbox"/> Sinus problems <input type="checkbox"/> Nose bleeds <input type="checkbox"/> Sore throat <input type="checkbox"/> Mouth sores <input type="checkbox"/> Dental Problems	<input type="checkbox"/> Coughing up blood <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Chronic cough <input type="checkbox"/> Blood clot in the lungs <input type="checkbox"/> Painful breathing <input type="checkbox"/> Wheezing <input type="checkbox"/> Chest pain <input type="checkbox"/> Irregular heart beat <input type="checkbox"/> Ankle/Hand swelling <input type="checkbox"/> Frequent diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Bloody stool <input type="checkbox"/> Nausea/Vomiting <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Incomplete urination <input type="checkbox"/> Painful urination <input type="checkbox"/> Bloody urine	<input type="checkbox"/> Muscle weakness <input type="checkbox"/> Joint pains/swelling <input type="checkbox"/> Clot in leg vein <input type="checkbox"/> Frequent headaches <input type="checkbox"/> Dizziness <input type="checkbox"/> Seizures <input type="checkbox"/> Numbness <input type="checkbox"/> Trouble walking <input type="checkbox"/> Fainting spells <input type="checkbox"/> Acne <input type="checkbox"/> Unwanted hair growth <input type="checkbox"/> Unusual lump or growth <input type="checkbox"/> Dry skin <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression			