Centered Health Physical Therapy
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Patient Profile

Please complete the following information in detail as this will assist us in designing the most effective and efficient individualized program for you. This will become part of your confidential medical and will not be shared without your authorization. Thank you for your effort. Please print clearly.

Last Name: _____ First Name: _____

Date of Birth: _____ Age: _____

Address: _____

Home Phone: _____ Work Phone: _____

Mobile Phone: _____ E-Mail: _____

Emergency Contact: _____ Phone: _____

How did you find out about Centered Health Physical Therapy? _____

What brings you to the office today? _____

Is this a work or accident related injury? Yes ____ No ____ If yes, complete below. If not, skip to primary physician.

Name of Adjuster or Contact Person: _____ Phone: _____

Name of Lawyer: _____ Phone: _____

Name of your Primary Physician: _____ Phone: _____

Name of Referring Physician, if different: _____ Phone: _____

Current Health Concerns

Describe the major complaints/challenges you have in order of their importance.

Date of Onset Brief Description

1. _____
2. _____
3. _____
4. _____

Describe the causes of these concerns (if known or suspected): _____

_____

Have you had the same or similar problems before? Yes ____ No ____

If yes, what have you done in the past to help resolve these issues? _____

_____

What increases your symptoms? _____

_____

What decreases your symptoms? _____

_____

Are your symptoms getting progressively worse? Yes ____ No ____

Currently, what have you done to help resolve these concerns? _____

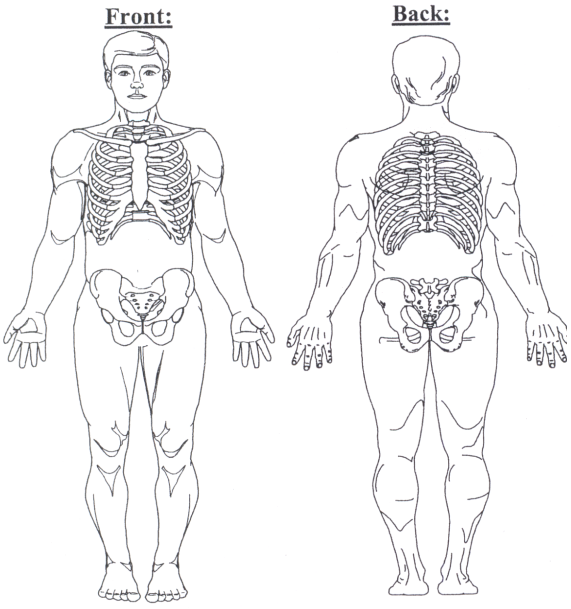
_____

Are your problems interfering with: Work ____ Daily Routine ____ Sleep ____ Exercise ____ Other_____

Are you currently pregnant? Yes ____ No ____ If yes, how far along? _____

Pain

Please shade or circle all areas of pain you are experiencing.



Please rate the frequency of pain you are experiencing:
75-100% of the time ____
50-75% of the time ____
25-50% of the time ____
0-25% of the time ____

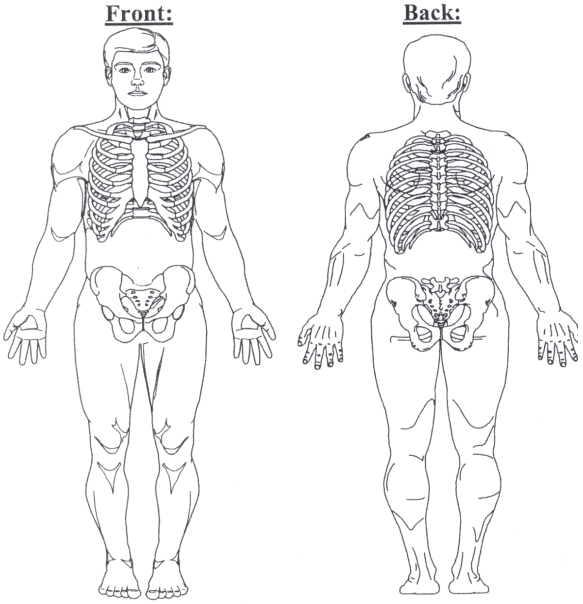
Please rate the intensity of pain you are experiencing from 0-10 (0=none, 10=severe): _____

Paresthesia

Please shade or circle all areas of funny sensation (tingling, burning, pins and needles, etc.) you are experiencing.

Please rate the frequency of paresthesia you are experiencing:
75-100% of the time ____
50-75% of the time ____
25-50% of the time ____
0-25% of the time ____

Please rate the intensity of paresthesia you are experiencing from 0-10 (0=none, 10=severe): _____



Previous Treatment

Have you recently been treated for this issue? Yes ____ No ____ If no, skip ahead.

Name of Healthcare Provider: _____ Phone: _____

What diagnostic tests were performed? Results? _____

_____

Was a diagnosis given? If yes, what was the diagnosis? _____

How was the condition treated? _____

_____

Results of treatment: Good ____ Fair ____ Poor ____

Current Treatment

Please list, if any, the other healthcare providers you are currently seeing for this condition: None ____

Name Phone Testing/Treatments

1. _____
2. _____
3. _____
4. _____
5. _____

Have there been any recent diagnostic tests performed? Results? _____

_____

Health Maintenance

Please indicate approximate dates and results of the last:

Date Results

Full Physical Exam: _____

Dental Exam: _____

Blood Work: _____

Lifestyle

How would you describe your general health? Excellent ____ Good ____ Fair ____ Poor ____

Are you currently working? Yes ___ No ___

If yes, what do you do for a living? _____

What does your job entail? _____

How many hours do you spend working in a given week? _____

Please indicate job satisfaction: Excellent ____ Good ____ Fair ____ Poor ____

If you are not working, do you anticipate on returning? Yes ____ No ____

Are you on disability insurance? Yes ___ No ___

Please check major stresses:

Job ____ New retirement ____ New baby ____ Change of marital status ____ Health problems ____ Family stress ____ Financial concerns ____ Abusive relationship ____ Other ____ please describe: _____

_____

On a scale of 0-10 (0=none, 10=severe), please indicate the level of stress you are currently experiencing: _____

How do you relax or relieve stress? _____

_____

Please indicate the amount of exercise you are currently engaged in.

Exercise	Days/week	Minutes/session	Exercise	Days/week	Minutes/session
Walk			Dance		
Run			Yoga		
Bike			Pilates		
Aerobic class					
Weight lifting					

Are you a smoker? Yes ____ No ____

If yes, how many years have you been a smoker? _____

Current Medications

Please itemize all medications you are currently using or have used recently. Please be sure to include all over the counter medications and hormones as well.

Drug	Reason for use	Dose	Length of use	Prescribing doctor

Current Supplements

Please list all vitamins, minerals, herbs and other natural products you are currently using or have used recently.

Drug	Reason for use	Dose	Length of use	Prescribing doctor

Surgeries and Hospitalizations

Please list all surgeries and hospitalizations, their approximate dates, their reasons and results.

Surgery/Study	Date	Reason	Results

Traumas, Illnesses, Accidents (not already listed)

Have you even been in an auto accident? Yes ____ No ____ If yes, approximate date: _____

Describe: _____

Have you had any sports injuries? Yes ____ No ____ If yes, approximate date: _____

Describe: _____

Please list any other falls, accidents, injuries and indicate their approximate dates: _____

_____

_____

Review of Systems

Please indicate with a '**C**' if you **currently have** or a '**P**' if you **previously had** any of the following.

	Constitutional		Mental		Neurological		Integumentary
	Severe fatigue		Anxiety		Dizziness		Skin rash / itching
	Fever		Depression		Fainting		Skin infections
	Night sweats		Other		Headaches		Brittle nails
	Poor sleep				Migraines		Recent hair loss
	Apathy				Numbness		
					Weakness		
					Tingling		

	Endocrine		Immune System		Eye and Ear		Respiratory
	Thyroid		Cancer		Loss of hearing		Freq. sore throats
	Diabetes		Autoimmune		Ringing in ears		Freq. sinus infections
	Other		Allergies		Recent loss of vision		Asthma
			Hay fever		Eye Pain		Difficulty breathing
			Lymph nodes enlarged		Dry eyes		Shortness of breath
			Recurrent colds/flu		Recurrent sinusitis		Chronic bronchitis
							Chronic cough
							Tuberculosis
							Pneumonia (bacterial)
							Pneumonia (viral)
							Chest pain

	Gastrointestinal		Cardiology/Hematology		Genitourinary		Gynecological
	Stomach ulcers		Chest pain		Kidney failure		Menstrual cramps
	Acid reflux		Heart disease		Kidney infection		PMS
	Gas and bloating		Heart failure		Kidney stones		Menopause
	Constipation		Stroke		Bladder infection		Heavy menstrual flow
	Diarrhea		Irregular heart beat		Prostate enlargement		Hot flashes
	Blood in stools		Hemorrhoids (internal)		Sexual problems		Irregular cycles
	Persistent nausea		Hemorrhoids (external)		Loss of libido		Breast issues
	Recurrent vomiting		Varicose veins		Infertility		
	Liver disease		Poor circulation		STD - HIV		
	Hepatitis		Anemia		STD - HPV		
	Abdominal Pain		Frequent nose bleeds		STD - other		
			Blood diseases				
			Easy bruising				

	Musculoskeletal		Metabolic		Other
	Arthritis		Loss of appetite		
	Neck pain		Weight gain		
	Upper back pain		Weight loss		
	Mid back pain		Weight redistribution		
	Low back pain				
	Leg pain				
	Arm pain				
	Stiffness				
	Hot/swollen joints				
	Ankle swelling				
	Fibromyalgia				