POWHATAN PHYSICAL THERAPY MEDICAL INFORMATION FORM

Name: _____ Date: _____

What brings you to see us today?_____

If we are seeing you for a painful condition, how long have you been experiencing pain? _____

1. Was this due to a personal injury? ☐ Yes ☐ No
2. Was this due to an auto accident? ☐ Yes ☐ No Accident State: _____
3. Was this due to a work-related accident? ☐ Yes ☐ No
4. Describe how you were hurt

   _____
   _____
   _____
   _____

5. On the scales below, please circle the number which best represents the severity of your pain.

Average for the last 48 hours:

No Pain Worst Pain Imaginable

0 1 2 3 4 5 6 7 8 9 10

Best for the last 48 hours:

No Pain Worst Pain Imaginable

0 1 2 3 4 5 6 7 8 9 10

Worst for the last 48 hours:

No Pain Worst Pain Imaginable

0 1 2 3 4 5 6 7 8 9 10

On the four body diagrams below, please mark all painful areas at this time; feel free to use your own words to describe each painful/affected area, or choose from the list provided:

Sharp and pin-point	Cramping/aching	Burning	Pounding	Numbness
Deep	Gnawing	Pulsating	Tingling	
Dull	Wave-like	Sharp	Continuous	
Aching	Not localized	Lancinating	Intermittent	
Cramping	Throbbing	Shocking		

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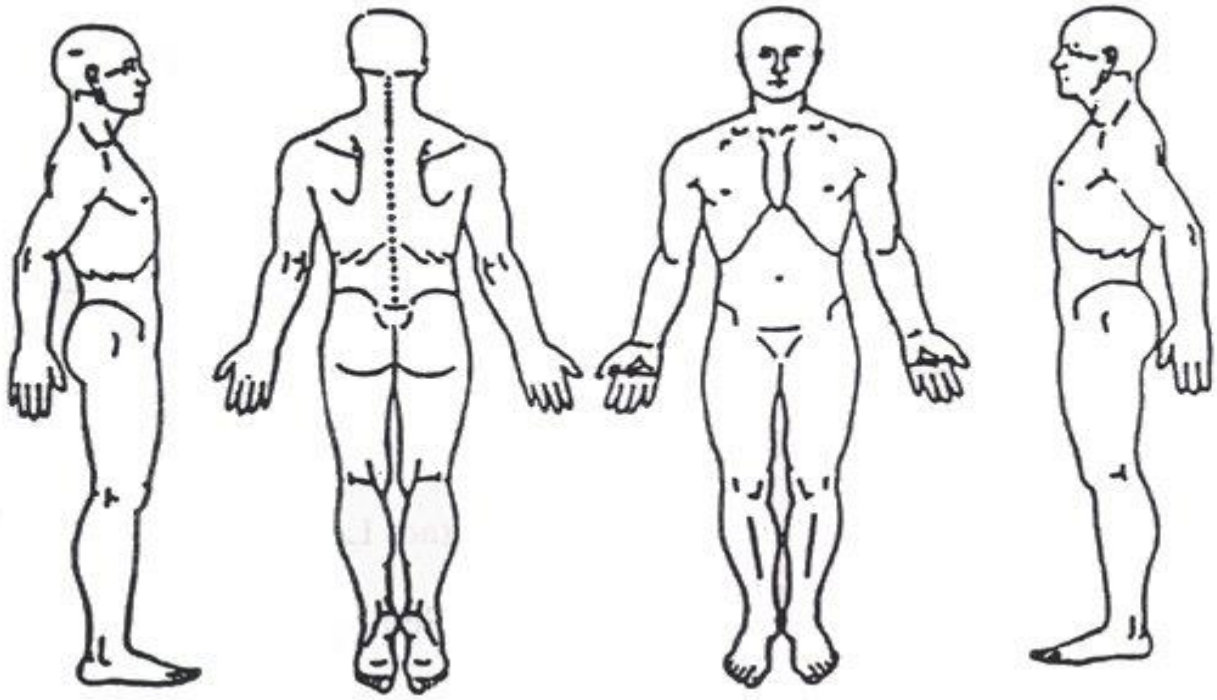

Please list any and all daily, work or recreational activities, as well as any specific movements or positions that make your pain worse, including:

Lying down Sitting Standing Walking Stress Coughing/sneezing/straining

Daily activities:_____
_____

Work duties:_____
_____

Recreational activities:_____
_____

Please list all specific movements or positions that alleviate or lesson your pain:

_____
_____
_____

Please list all previous or current treatment received for your ailment._____
_____

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Is your pain getting better ☐, worse ☐, or staying the same ☐?

If you reported low back pain, please refer to Appendix A and answer all questions accordingly.

If you reported abdominal pain, please refer to Appendix B and answer all questions accordingly.

Are you currently experiencing any of the following? Please circle those that apply:

Fatigue	Weight loss/gain (unintentional)	Numbness
Malaise	Nausea/vomiting	Weakness
Fever	Dizziness/lightheadedness/falls	Change in cognition/mentation

Regarding your mental/psychological well-being, please answer the following 3 questions:

1. In the past month, have you often been bothered by feeling down, depressed, or hopeless? ☐ Yes ☐ No
2. In the past month, have you often been bothered by little interest or pleasure in doing things? ☐ Yes ☐ No
3. Is this something with which you would like help? ☐ Yes ☐ No

PAST MEDICAL HISTORY: please circle all that apply; if YES to the first 3, please see Appendix C. If YES to 5-9, Appendix E

1. Heart disease	11. Other connective tissue disease	21. Leukemia	31. Headaches
2. Chest pain	12. Stroke/TIA	22. Lymphoma	32. Anemia
3. Respiratory disease	13. Fibromyalgia	23. Other Cancer: _____	33. Epilepsy/seizures
4. High blood pressure	14. Blood Clots	24. Pregnant (Appendix D)	34. Emphysema
5. Diabetes	15. Lung Cancer	25. Previous pregnancy (Appendix D)	35. Kidney Disease
6. Hyperthyroid	16. Breast Cancer	26. Recent Infection: _____	36. Liver Disease
7. Hypothyroid	17. Prostate Cancer	27. Asthma	37. Osteoarthritis
8. Osteoporosis	18. Colon Cancer	28. Chemical Dependency	
9. Metabolic Disorders	19. Skin Cancer	29. COPD	
10. Rheumatoid Arthritis	20. Bone Cancer	30. Epilepsy/seizures	

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Please list previous surgeries/dates:

General: _____

_____

Orthopedic: _____

_____

Other: _____

_____

Please list any diagnostic tests:

Radiographs (X-Rays) _____

CT Scan _____

MRI _____

EMG/NCV Nerve Studies _____

Injections _____

Other: _____

_____

Describe your regular exercise routine: _____

_____

Do you smoke? ☐ Yes ☐ No

If yes, how many packs/day? _____

Do you drink alcohol? ☐ Yes ☐ No

If yes, how many drinks/day/week? _____

Office use only: Functional Scales Scores

Neck Index: _____

Quick Dash: _____

Oswestry: _____

Harris Hip: _____

LEFS: _____

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Medication Record

Please list all current medications, including anti-inflammatory (steroids, NSAID's), pain, cholesterol, blood pressure, mental health, cardiac, respiratory, gastrointestinal medicines and over the counter supplements.

	MEDICATION	DOSAGE	FREQUENCY
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			

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APPENDIX A FOR ALL LBP PATIENTS:

11 RED FLAG ITEMS: LBP population

1. Have you experienced recent trauma? ☐ Yes ☐ No
2. Have you been diagnosed with osteoporosis? ☐ Yes ☐ No
3. History of cancer? ☐ Yes ☐ No
4. History of abdominal aortic aneurysm? ☐ Yes ☐ No
5. Recent infection? ☐ Yes ☐ No
6. Recent fever/chills/night sweats? ☐ Yes ☐ No
7. Recent unexplained weight loss? ☐ Yes ☐ No
8. Have you been on prolonged steroid use? ☐ Yes ☐ No
9. Are you and IV drug user? ☐ Yes ☐ No
10. Have you had recent transplant surgery? ☐ Yes ☐ No
11. Do you have night pain unrelated to movement? ☐ Yes ☐ No
12. Have you experienced a recent numbness in your groin, perianal, labium or testicles? ☐ Yes ☐ No
13. Have you experienced recent bowel or bladder dysfunction, including urinary retention, changes in frequency, incontinence, pain with urination? ☐ Yes ☐ No
14. Have you experienced a recent increase in numbness/tingling, and or a decrease in leg strength? ☐ Yes ☐ No

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APPENDIX B

Cluster 1

1. Does coughing, sneezing, or taking a deep breath make your pain worse? ☐ Yes ☐ No
2. Do activities such as bending, sitting, lifting, twisting, or turning over in bed make your pain worse?
   ☐ Yes ☐ No
3. Has there been any change in your bowel habit since the start of your symptoms? ☐ Yes ☐ No

Cluster 2.

1. Does eating certain foods make your pain worse? ☐ Yes ☐ No
2. Has your weight changed since your symptoms started? ☐ Yes ☐ No

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Appendix C

Physical Activity Readiness Questionnaire - PAR-Q (revised 2002)

PAR-Q & YOU

(A Questionnaire for People Aged 15 to 69)

Regular physical activity is fun and healthy, and increasingly more people are starting to become more active every day. Being more active is very safe for most people. However, some people should check with their doctor before they start becoming much more physically active.

If you are planning to become much more physically active than you are now, start by answering the seven questions in the box below. If you are between the ages of 15 and 69, the PAR-Q will tell you if you should check with your doctor before you start. If you are over 69 years of age, and you are not used to being very active, check with your doctor.

Common sense is your best guide when you answer these questions. Please read the questions carefully and answer each one honestly: check YES or NO.

YES	NO		
☐	☐	1.	**Has your doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor?**
☐	☐	2.	**Do you feel pain in your chest when you do physical activity?**
☐	☐	3.	**In the past month, have you had chest pain when you were not doing physical activity?**
☐	☐	4.	**Do you lose your balance because of dizziness or do you ever lose consciousness?**
☐	☐	5.	**Do you have a bone or joint problem (for example, back, knee or hip) that could be made worse by a change in your physical activity?**
☐	☐	6.	**Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure or heart condition?**
☐	☐	7.	**Do you know of any other reason why you should not do physical activity?**

If you answered YES to one or more questions

Talk with your doctor by phone or in person BEFORE you start becoming much more physically active or BEFORE you have a fitness appraisal. Tell your doctor about the PAR-Q and which questions you answered YES.

- You may be able to do any activity you want — as long as you start slowly and build up gradually. Or, you may need to restrict your activities to those which are safe for you. Talk with your doctor about the kinds of activities you wish to participate in and follow his/her advice.
- Find out which community programs are safe and helpful for you.

NO to all questions

If you answered NO honestly to all PAR-Q questions, you can be reasonably sure that you can:

- start becoming much more physically active – begin slowly and build up gradually. This is the safest and easiest way to go.
- take part in a fitness appraisal – this is an excellent way to determine your basic fitness so that you can plan the best way for you to live actively. It is also highly recommended that you have your blood pressure evaluated. If your reading is over 144/94, talk with your doctor before you start becoming much more physically active.

DELAY BECOMING MUCH MORE ACTIVE:

- if you are not feeling well because of a temporary illness such as a cold or a fever – wait until you feel better; or
- if you are or may be pregnant – talk to your doctor before you start becoming more active.

PLEASE NOTE: If your health changes so that you then answer YES to any of the above questions, tell your fitness or health professional. Ask whether you should change your physical activity plan.

Informed Use of the PAR-Q: The Canadian Society for Exercise Physiology, Health Canada, and their agents assume no liability for persons who undertake physical activity, and if in doubt after completing this questionnaire, consult your doctor prior to physical activity.

No changes permitted. You are encouraged to photocopy the PAR-Q but only if you use the entire form.

NOTE: If the PAR-Q is being given to a person before he or she participates in a physical activity program or a fitness appraisal, this section may be used for legal or administrative purposes.

"I have read, understood and completed this questionnaire. Any questions I had were answered to my full satisfaction."

NAME _____

SIGNATURE _____ DATE _____

SIGNATURE OF PARENT or GUARDIAN (for participants under the age of majority) _____ WITNESS _____

Note: This physical activity clearance is valid for a maximum of 12 months from the date it is completed and becomes invalid if your condition changes so that you would answer YES to any of the seven questions.

Supported by: Health Canada Santé Canada

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APPENDIX D

PREGNANT PATIENT INTERVIEW

1. Complications for present pregnancy?

   _____

2. Complications with prior pregnancy?

   _____

3. Did your present musculoskeletal symptoms exist before pregnancy or with prior pregnancies?

   ☐ Yes ☐ No

4. Presently experiencing urinary or anal incontinence? ☐ Yes ☐ No

5. Medications presently taking and what was stopped due to pregnancy?

   _____

   _____

   _____

   _____

   _____

POST-PARTUM PATIENT INTERVIEW

1. Bed rest during pregnancy? ☐ Yes ☐ No
2. Type of delivery: Caesarean or vaginal?
3. Complications?

   _____

4. Episiotomy or tears in perineum?
5. Forceps or vacuum extraction?
6. Incontinence? ☐ Yes ☐ No
7. Current symptoms present during or prior to pregnancy?

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APPENDIX E

1. Have you ever had head/neck radiation or cranial/head surgery? ☐ Yes ☐ No
2. Have you ever had a head injury? ☐ Yes ☐ No
3. Have you been diagnosed with diabetes, or "sugar" in your blood? ☐ Yes ☐ No
4. Any changes in vision, such as blurred vision, double vision, loss of peripheral vision, or sensitivity to light? ☐ Yes ☐ No
5. Have you had an increase in your thirst or number of times you need to urinate? ☐ Yes ☐ No
6. Increase in appetite? ☐ Yes ☐ No
7. Do you bruise easily? ☐ Yes ☐ No
8. Do cuts/injuries heal slowly? ☐ Yes ☐ No
9. Decrease in muscle strength? ☐ Yes ☐ No
10. Muscle cramping or twitching? ☐ Yes ☐ No
11. Unexplained fatigue? ☐ Yes ☐ No
12. Increase in collar size, difficulty breathing or swallowing? ☐ Yes ☐ No
13. Any changes in skin color? ☐ Yes ☐ No
14. Have you been told you have osteoporosis, or brittle bones? ☐ Yes ☐ No
15. Cushing's Disease/Syndrome? ☐ Yes ☐ No
16. Difficulty going up stairs or getting out of a chair? ☐ Yes ☐ No

If you have been diagnosed with Diabetes:

1. What type of insulin do you take? _____
2. What is your schedule? _____
3. Do you ever have episodes of hypoglycemia or insulin reaction? ☐ Yes ☐ No
4. Do you carry a source of sugar for emergencies? ☐ Yes ☐ No
5. Have you ever had diabetic ketoacidosis? ☐ Yes ☐ No
6. Do you use the finger stick method for determining blood glucose levels? ☐ Yes ☐ No
7. Do you have difficulty maintaining your "numbers"? ☐ Yes ☐ No
8. Do you have any burning, numbness or a loss of sensation in your hands or feet? ☐ Yes ☐ No

Powhatan Physical Therapy Medical Intake Justification

Powhatan Physical Therapy is in Powhatan County, Virginia, a rural community approximately 30 miles west of Richmond, Virginia. Founded by Gregg A. Tobey, PPT is in it's 19th year of operation. Providers on site include myself, as well as Danielle Smith, PTA, and Steven Touchstone, PTA. We also have a certified massage therapist available on Thursdays in clinic to augment our treatments. We see approximately 95% musculoskeletal cases; the other 5% being neurological issues. You will note several appendices to the medical intake sheet that serve particular sub-groups of patients; these are separate from the main form as to garner more pertinent information for peculiar situations.

Regarding the body diagram and words used to describe pain, the Rhodeghero(1) paper provided an exhaustive list to help distinguish between abdominal pain of musculoskeletal versus visceral origin. The Cutrone(2) lecture on recognizing atypical signs/symptoms points out other descriptors I used for various system disorders to differentiate vascular, neurological or visceral etiologies of pain. Rhodeghero also provides two question clusters regarding abdominal pain of musculoskeletal origin that I used to formulate Appendix B for all patients reporting abdominal pain on the intake sheet.

Appendix A for all patients reporting LBP as a complaint is based upon Leerar's(3) paper on documentation of red flags for patients in this category. The section "are you currently experiencing any of the following?" is derived from the review of systems lecture by Cutrone(4): general health components of review of systems.

Mental hygiene issues are addressed with the three-question cluster by Arroll et al.(5) I have not used these questions clinically here to date but will do so moving forward. As per this study, approximately 33% of the general population is suffering from some form of depression; we don't want to miss this, as it has a significant effect on response to treatment and quality of life.

I used Boissonnault and Badke's(6) patient survey, as well as the Endocrine and Metabolic Signs and Symptoms lecture (Appendix E), to create a much more inclusive and complete list of potential past medical history findings. For those patients reporting a history of cardiovascular disorders, I will have them also complete the PAR-Q questionnaire (Appendix C) before initiating exercise. We see a large number or THA and TKA patients who by nature are typically older with many co-morbidities, and we will be employing this with that population as well.

We do not see too many pregnant patients currently, but we will direct all pregnant women to Appendix D, derived from the Obstetrics lecture by Koszalinski(7).

Rhodeghero, Jet al., Abdominal Pain in PT Practice: 3 Patient Cases, JOSPT 2013, 43(2), 44-53

Cutrone Lecture, Recognizing Atypical Symptoms/Signs (2,4)

Leerar, P et al. Documentation of Red Flags by PT's for Patients with LBP, The Journal of Manual and Manipulative Therapy, 2007, 15(1); 42-49

Arroll, B et al., Effect of the Addition of a "Help" Question to two Screening Questions on Specificity for Diagnosis of Depression in General Practice: Diagnostic Validity Study, BMJ 2005;

Endocrine and Metabolic Signs and Symptoms lecture, week 6

Boissonnault, W, and Badke, MB, Collecting Health History Information: The Accuracy of a Patient Self-Administered Questionnaire in an Orthopedic Out-Patient Setting, PT, 6/2005, 85, 6; pp531-543

Koszalinski lecture, Obstetrics