Body In Balance
PHYSICAL THERAPY INC.

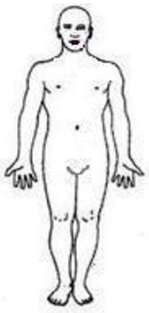
Returning General Patient Information

To ensure we keep up to date with your care, please provide us with the important background information on the following form. If you do not understand a question, leave it blank and your physical therapist will assist you. Thank you for trusting us again with your care.

1. What is your main complaint or problem?_____
2. Do you have a history of similar episodes/complaints? ____YES ____NO
3. If yes, please explain: _____
4. When did this episode begin? _____
5. How did your problem start? _____
6. Did you have surgery for this injury? ____YES ____NO Date of Surgery:_____
7. Please rate your pain on the scale below by circling the number(s) below:

0	1	2	3	4	5	6	7	8	9	10
no pain		mild discomfort				moderate discomfort			extreme discomfort	

8. Please indicate the painful areas by shading the model:

Right side  Left side

Left side  Right side

9. Which of the following words best describes your pain?

___sharp	___dull	___burning	___throbbing
___tingling	___numb	___aching	___shooting
___variable	___constant	___radiating (moves around)	

10. What positions/activities make your pain worse? _____
11. What positions/activities lessen your pain?_____
12. Does your pain ease when resting in a comfortable position? __YES ___NO
13. Does your current complaint affect your sleep? __YES ___NO

If yes, please explain: _____

Patient Name _____ DOB _____

14. List three activities that you are unable to do due to your discomfort?

1. _____ 2. _____3. _____

15. Check all the activities that are limited by your conditions:

___Walking	___Sitting	___Standing	___Lifting
___ Carrying	___Sleeping	___ Driving	___ Bending
___ Running	___ Dressing	___ Urinating	___ Coughing
___ Sneezing	___ Other: _____		

Comments: _____
_____

16. Have you been treated for this condition by any of the following?

__ Medical Doctor __Osteopath __Dentist

__ Psychiatrist/ Psychologist __Physical Therapist __Occupational Therapist

__Personal Trainer __Chiropractor Other: _____

17. Have you used any treatment at home? __YES ___NO

If yes, what kind? _____

18. Are you receiving treatment for any other medical condition? __YES ___NO

If yes, please list: _____

19. Have you recently taken any antibiotics? _____

20. Please list any surgeries, including elective (such as implants) that you have had:

1. _____ Reason: _____

2. _____ Reason: _____

21. Have you **EVER** been diagnosed with any of the following conditions?

__YES ___NO Cancer	__YES ___NO Heart problems
__YES ___NO High Blood pressure	__YES ___NO Thyroid problems
__YES ___NO Circulatory problems	__YES ___NO Diabetes
__YES ___NO Asthma	__YES ___NO Multiple Sclerosis
__YES ___NO Stomach ulcers	__YES ___NO Rheumatoid arthritis
__YES ___NO Chemical Dependency	__YES ___NO Other arthritic conditions
__YES ___NO Depression	__YES ___NO Hepatitis
__YES ___NO Tuberculosis	__YES ___NO Stroke
__YES ___NO Kidney disease	__YES ___NO Blood clots
__YES ___NO Osteoporosis	__YES ___NO Urinary Incontinence

Other: _____

22. Have you experienced any unusual symptoms?

__YES ___NO Weight loss
__YES ___NO Nausea vomiting
__YES ___NO Dizziness
__YES ___NO Headaches
__YES ___NO Fatigue
__YES ___NO Weakness
__YES ___NO Fever/Chills/Sweat
__YES ___NO Numbness tingling

23. Allergies: Latex: __YES ___NO Medications:_____
Other:_____

24. Please list any physician prescribed medication you are currently taking:

1._____ Reason: _____
2._____ Reason: _____
3._____ Reason: _____
4._____ Reason: _____

25. Please list any non- prescribed medication you are currently taking:

1._____ Reason: _____
2._____ Reason: _____
3._____ Reason: _____
4._____ Reason: _____

26. Self-Assessment: Please check 1-10 (10 being extremely high)

	1	2	3	4	5	6	7	8	9	10		1	2	3	4	5	6	7	8	9	10
Quality of life											Overall Health										
Energy level											Nutritional Habits										
Physical strength											Physical Appearance										
Physical endurance											Flexibility										
Aerobic endurance											Agility- balance coordination										

1. Are you currently working outside of the home? __YES ___NO

2. Please write your occupation and describe the physical demands involved:

_____

3. Please expand on any other physical activities that you are involved in:

_____

4. Do you have children? __YES ___NO How many? _____

5. Social History:

   Tobacco use: ___ per day Caffeine use: ___ per day

   Alcohol use: ___per day Recreational drugs: ___ per day

6. What is your average level of stress 1-10? (10 being extremely high) _____

7. What decreases your stress?

   _____What are your goals/expectations from therapy?

   ___ Relieve pain ___Return to work ___Increase range of motion

   ___ Return to sports ___ Return to recreational activities

   Other: _____

8. What would be your barriers to achieving your goals?

___ Pain ___Low energy ___Lack of support

___Procrastination ___ Lack of motivation ___ Too many commitments

___Dislike exercise Other: _____

Thank you for taking the time to fill out this questionnaire, we are committed to providing the best possible care to maximize your results.

Patient Signature: _____ Date: _____