



MAJERUS & CO. PHYSICAL THERAPY

PATIENT HEALTH HISTORY

Name (First, Last): _____

Date of Birth: _____

Primary Care Physician: _____

Today's Date: _____

Please complete each section below. If a section or question does not apply to your condition, please write "N/A".

Present Illness / Injury: Please describe your reason for today's visit: _____

_____ Date of Injury or Onset: _____

Current Medications: Please list all medications you are taking, and the dosage. If you are not currently taking any medications, please check **NONE**

Known Allergies: Please list below. If you do not have any known allergies, please check **NONE**

Please check if you (or a caregiver) are allergic to the following? Latex Adhesives

Medical History: Please check all that apply or check **NONE**

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Low blood sugar | <input type="checkbox"/> Seizures(list) _____ |
| <input type="checkbox"/> Arrhythmia | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Skin diseases |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fractures (list) _____ | <input type="checkbox"/> Muscular Dystrophy | <input type="checkbox"/> Sleep difficulties |
| <input type="checkbox"/> Back pain | <input type="checkbox"/> Headache | <input type="checkbox"/> Neurologic disorders | <input type="checkbox"/> Sprains (list) _____ |
| <input type="checkbox"/> Blood disorders | <input type="checkbox"/> Head injury | <input type="checkbox"/> Non-healing wounds | <input type="checkbox"/> Stomach problems |
| <input type="checkbox"/> Bowel or Bladder problems | <input type="checkbox"/> Heart attack | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Congestive heart failure | <input type="checkbox"/> Hepatitis (list) _____ | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Thyroid/Hormone problems |
| <input type="checkbox"/> COPD (Emphysema) | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Infectious diseases | <input type="checkbox"/> Prostate problems | <input type="checkbox"/> Urinary/Kidney problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Learning/develop disabilities | <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> Varicose/Spider veins |
| <input type="checkbox"/> DVT/Blood clots | <input type="checkbox"/> Other: _____ | | |

If female, are you or could you be pregnant? Yes No

Please indicate how frequently you use: Tobacco _____ Alcohol _____ Other drugs _____

Have you had any of the following in the past year? Please check all that apply or check **NONE**

- | | | | | | |
|---------------------------------------|--|---|--|--|-----------------------------------|
| <input type="checkbox"/> Cough | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Vision |
| <input type="checkbox"/> Coordination | <input type="checkbox"/> Fever, Chills, Sweats | <input type="checkbox"/> Loss of Appetite | <input type="checkbox"/> Nausea | <input type="checkbox"/> Swallowing Difficulty | <input type="checkbox"/> Weakness |

(Patient Health History Continued)

Imaging History: If you have had diagnostic imaging related to your present illness or injury (i.e. X-Ray, MRI, CT), please list what was done, where, and when it was done (month/year). If none applies, check **NONE**

Surgical History: List all surgeries performed within the last 12 months, and any that would relate to your visit here today. Also, please list the month & year of each surgery. If none applies, check **NONE**

Cancer History: Complete only if applicable to you.

Diagnosis: _____ Surgery (type): _____

Radiation treatments (body part): _____ Was a "boost" dose included? Yes No

Chemotherapy (drug type/how often?): _____

Reactions to cancer treatments (check all that apply):

- Weight Loss Pain Skin Tightness Shortness of Breath Nausea/Vomiting Decreased joint motion
 Weight Gain Fatigue Hair Loss Numbness/Tingling Cardiac Problem Decreased muscle strength

Swelling (Edema) History: Complete only if applicable to you.

When did your swelling start? _____

What makes it better? _____

What makes it worse? _____

What has been done to treat it (include medications, pumps, other devices, previous physical therapy or massage)?

Does anyone in your family have lymphedema or a swelling disorder? _____

****If you have any questions about this form or have any additional information you would like to share with your therapist, please bring it to their attention during your visit. Thank you.**

NAME _____ DATE _____
 TIME _____ AM/PM Initial Visit Discharge Visit

FUNCTIONAL INDEX

Choose the one answer in each section that best describes your condition.

WALKING

- Symptoms do not prevent me walking any distance.
- Symptoms prevent me walking more than 1 mile.
- Symptoms prevent me walking more than 1/2 mile.
- Symptoms prevent me walking more than 1/4 mile.
- I can only walk using a stick or crutches.
- I am in bed most of the time and have to crawl to the toilet.

WORK

(Applies to work in home and outside)

- I can do as much work as I want to.
- I can only do my usual work, but no more.
- I can do most of my usual work, but no more.
- I cannot do my usual work.
- I can hardly do any work at all (only light duty).
- I cannot do any work at all.

PERSONAL CARE

(Washing, Dressing, etc.)

- I can manage all personal care without symptoms.
- I can manage all personal care with some increased symptoms.
- Personal care requires slow, concise movements due to increased symptoms.
- I need help to manage some personal care.
- I need help to manage all personal care.
- I cannot manage any personal care.

SLEEPING

- I have no trouble sleeping.
- My sleep is mildly disturbed (less than 1 hr. sleepless).
- My sleep is mildly disturbed (1–2 hrs. sleepless).
- My sleep is moderately disturbed (2–3 hrs. sleepless).
- My sleep is greatly disturbed (3–5 hrs. sleepless).
- My sleep is completely disturbed (5–7 hrs. sleepless).

RECREATION/SPORTS

(Indicate Sport if Appropriate _____)

- I am able to engage in all my recreational/sports activities without increased symptoms.
- I am able to engage in all my recreational/sports activities with some increased symptoms.
- I am able to engage in most, but not all of my usual recreational/sports activities because of increased symptoms.
- I am able to engage in a few of my usual recreational/sports activities because of my increased symptoms.
- I can hardly do any recreational/sports activities because of increased symptoms.
- I cannot do any recreational/sports activities at all.

ACUITY *(Answer on initial visit.)*

How many days ago did onset/injury occur? _____ days

CONCENTRATION

- I can concentrate fully when I want to with no difficulty.
- I can concentrate fully when I want to with slight difficulty.
- I have a fair degree of difficulty in concentrating when I want to.
- I have a lot of difficulty in concentrating when I want to.
- I have a great deal of difficulty in concentrating when I want to.
- I cannot concentrate at all.

HEADACHES

- I have no headaches at all.
- I have slight headaches which come less than 3 per week.
- I have moderate headaches which come infrequently.
- I have moderate headaches which come 4 or more per week.
- I have severe headaches which come frequently.
- I have headaches almost all of the time.

READING

- I can read as much as I want without increased symptoms.
- I can read as much as I want with slight symptoms.
- I can read as much as I want with moderate symptoms.
- I cannot read as much as I want because of moderate symptoms.
- I can hardly read at all because of severe symptoms.
- I cannot read at all.

DRIVING

- I can drive my car or travel without any extra symptoms.
- I can drive my car or travel as long as I want with slight symptoms.
- I can drive my car or travel as long as I want with moderate symptoms.
- I cannot drive my car or travel as long as I want because of moderate symptoms.
- I can hardly drive at all or travel because of severe symptoms.
- I cannot drive my car or travel at all.

LIFTING

- I can lift heavy weights without extra symptoms.
- I can lift heavy weights, but it gives extra symptoms.
- My symptoms prevent me from lifting heavy weights, but I manage if they are conveniently positioned (e.g. on a table).
- My symptoms prevent me from lifting heavy weights, but I manage light to medium weights if they are conveniently positioned.
- I can lift only very light weights.
- I cannot lift or carry anything at all.

Please complete opposite side

PAIN INDEX

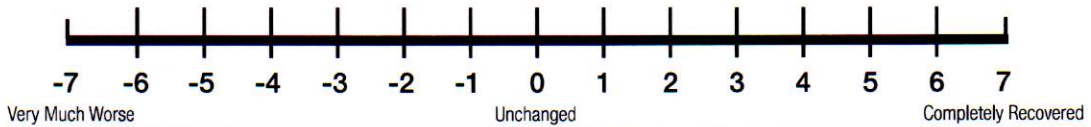
Please indicate the worst your pain has been in the last 24 hours on the scale below

No Pain  Worst Pain Imaginable

PLEASE DO NOT COMPLETE THE FOLLOWING SECTIONS ON FIRST VISIT

GLOBAL RATING OF CHANGE

With respect to the reason you sought treatment, how would you describe yourself now compared to your first treatment at our clinic?
(Circle one)



WORK STATUS (check most appropriate)

- 1. No lost work time
- 2. Return to work without restriction
- 3. Return to work with modification
- 4. Have not returned to work
- 5. Not employed outside the home

Work days lost due to condition: _____ days

I am aware that the information gathered on this form may be used anonymously for research or publication. Please initial: _____