



# 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**

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**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**

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**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)?

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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

**STAIRS**

- I can walk stairs comfortably without a rail.
- I can walk stairs comfortably, but with a crutch, cane, or rail.
- I can walk more than 1 flight of stairs, but with increased symptoms.
- I can walk less than 1 flight of stairs.
- I can manage only a single step or curb.
- I am unable to manage even a step or curb.

**UNEVEN GROUND**

- I can walk normally on uneven ground without loss of balance or use of a cane or crutches.
- I can walk on uneven ground, but with loss of balance or with the use of a cane or crutches.
- I have to walk very carefully on uneven ground without using a cane or crutches.
- I have to walk very carefully on uneven ground even when using a cane or crutches.
- I have to walk very carefully on uneven ground and require physical assistance to manage it.
- I am unable to walk on uneven ground.

**STANDING**

- I can stand as long as I want without increased symptoms.
- I can stand as long as I want, but it gives me extra symptoms.
- Symptoms prevent me from standing for more than 1 hour.
- Symptoms prevent me from standing for more than 30 minutes.
- Symptoms prevent me from standing for more than 10 minutes.
- Symptoms prevent me from standing at all.

**SQUATTING**

- I can squat fully without the use of my arms for support.
- I can squat fully, but with symptoms or with use of my arms for support.
- I can squat 3/4 of my normal depth, but less than fully.
- I can squat 1/2 of my normal depth, but less than 3/4.
- I can squat 1/4 of my normal depth, but less than 1/2.
- I am unable to squat any distance due to symptoms.

**SITTING**

- I can sit in any chair as long as I like.
- I can only sit in my favorite chair as long as I like.
- My symptoms prevent me sitting more than 1 hour.
- My symptoms prevent me sitting more than 1/2 hour.
- My symptoms prevent me sitting more than 10 minutes.
- My symptoms prevent me from sitting at all.

\* Lumbar questions adapted from Oswestry.

Please complete opposite side

**PAIN INDEX**

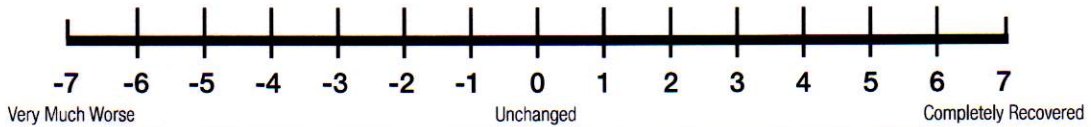
Please indicate the worst your pain has been in the last 24 hours on the scale below

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: \_\_\_\_\_