



# 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**

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

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**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

**CONDITION (CHECK ALL THAT APPLY)**

- (A) Bladder incontinence       (C) Bowel incontinence       (E) Pelvic/perineal pain  
 (B) Urinary urgency/frequency       (D) Fecal urgency       (F) Other

**ACUITY** (Answer on initial visit.)

How long ago did onset of symptoms occur? \_\_\_\_\_

**FUNCTION**

To what degree does your condition interfere with your participation in the following activities: (if you have bowel or bladder problems, rate interference when you are NOT using a pad or leakage protection).

	Never Interferes	10-20% of the time	30-40% of the time	50-60% of the time	70-80% of the time	Always Interferes
1. Household Activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Physical Activity/Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Intimate Relationships	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Sitting through long events (more than 3 hours)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Work Activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Activities without bathroom access	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Travel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Sleep (# times/night your sleep is interrupted)	<input type="checkbox"/> 0x	<input type="checkbox"/> 1x	<input type="checkbox"/> 2x	<input type="checkbox"/> 3x	<input type="checkbox"/> 4x	<input type="checkbox"/> 5+x
9. Number absorbent products used per day to manage your condition	<input type="checkbox"/> 0x	<input type="checkbox"/> 1x	<input type="checkbox"/> 2x	<input type="checkbox"/> 3x	<input type="checkbox"/> 4x	<input type="checkbox"/> 5+x

**10. PLEASE INDICATE TYPE OF PROTECTION USED**

- (A) none       (D) medium flow pad  
 (B) tissue/paper towels       (E) heavy flow pad  
 (C) panty liner       (F) specialty pad/protective garment

11. Number of bowel/urine leakage accidents per 24 hours? \_\_\_\_\_

12. Frequency of daytime urination? \_\_\_\_\_

13. Frequency of nighttime urination? \_\_\_\_\_

**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)

