

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.**

FUNCTIONAL INDEX

Choose the one answer in each section that best describes your ability to complete daily activities during the past week.

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, Grooming, 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 disturbed 1-2 hrs.
- My sleep is disturbed 2-3 hrs.
- My sleep is disturbed 3-5 hrs.
- My sleep is completely disturbed (5-7 hrs. sleepless).

LEISURE/SPORTS

(Indicate Sport if Appropriate _____)

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

REACHING

- I can reach a high shelf to place an empty cup without increased symptoms.
- I can reach a high shelf to place an empty cup with some increased symptoms.
- I cannot reach a high shelf to place an empty cup, but I can reach up to a lower shelf without increased symptoms.
- I cannot reach a lower shelf without increased symptoms, but I can reach counter height to place an empty cup.
- I cannot reach my hand above waist level without increased symptoms.
- I cannot reach at all.

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

LIFTING

- I can lift heavy weights without difficulty.
- I can lift heavy weights but it gives extra pain.
- I cannot lift heavy weights overhead, but I can manage if they are positioned on a table.
- I can lift light to medium weights if they are conveniently positioned.
- I can lift only very light weights.
- I cannot lift or carry anything at all with my involved hand.

CARRYING

- I can carry heavy loads without increased symptoms.
- I can carry heavy loads with some increased symptoms.
- I cannot carry heavy loads overhead, but I can manage if they are positioned close to my trunk.
- I cannot carry heavy loads, but I can manage light to medium loads if they are positioned close to my trunk.
- I can carry very light weights with some increased symptoms.
- I cannot carry anything at all.

DRIVING

- I can drive without difficulty.
- I can drive my car as long as I want to with slight pain.
- I am limited to using one hand, but can drive necessary distances.
- I can drive as long as I want to with moderate pain.
- I can drive only limited distances because of severe pain or limited hand use.
- I cannot drive my car at all.

DEXTERITY

- I have no difficulty performing fine manipulation tasks.
- I experience slight discomfort, stiffness, or swelling with regular tasks.
- I perform tasks at a slower pace, or activity is occasionally limited by symptoms.
- I perform tasks at a slower pace, and I am frequently limited by symptoms of stiffness, swelling, or discomfort.
- I tolerate only the very lightest tasks and infrequently handle objects.
- I cannot do fine manipulation tasks.

WRITING

- I can write as long as I want to without symptoms.
- I can write as long as I want to with adaptive equipment or setup.
- I can write with some difficulty or limitation.
- I have a lot of difficulty with writing and I am frequently limited.
- I can write my name only.
- I am unable to tolerate writing at all.

ACUITY (Answer on initial visit.)

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

Please complete opposite side

PAIN INDEX

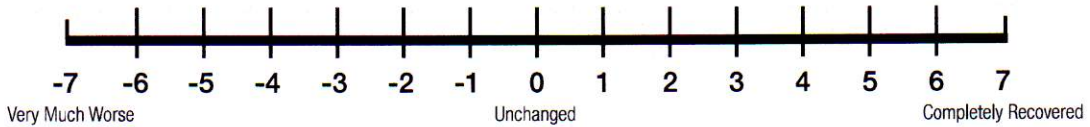
Please indicate the worst your pain has been in the last 24 hours on the scale below

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: _____