BELLEFONTAINE PHYSICAL THERAPY, LTD

Date _____

1 Name:

_____
a Last

_____ _____ _____
b First c MI d Jr/Sr

2 Street Address: _____

_____ _____
City State Zip

3 Date of Birth: Month ☐☐ Day ☐☐ Year ☐☐☐☐

4 Sex: a ☐ Male b ☐ Female

5 Are you: a ☐ Right-handed b ☐ Left-handed

6 Type of Insurance: a ☐ Insurer _____
b ☐ Workers' Comp c ☐ Medicare d ☐ Self-pay e ☐ Other

7 Race
a ☐ Asian
b ☐ Native Hawaiian/ Pacific Islander
c ☐ Black
d ☐ White

8 Ethnicity
a ☐ Hispanic or Latino
b ☐ Not Hispanic or Latino

9 Language
a ☐ English understood?
b ☐ Interpreter needed?
c ☐ Language you speak most often: _____

10 Education
a Highest grade completed (Circle one): 1 2 3 4 5 6 7 8 9 10 11 12
b ☐ Some college / technical school
c ☐ College graduate
d ☐ Graduate school / advanced degree

## SOCIAL HISTORY

11 Cultural/Religious
Any customs or religious beliefs or wishes that might affect care?
_____

12 With whom do you live?
a ☐ Alone
b ☐ Spouse only
c ☐ Spouse and other(s)
d ☐ Child (not spouse)
e ☐ Other relative(s) (not spouse or children)
f ☐ Group setting
g ☐ Personal care attendant
h ☐ Other:

13 Have you completed an advance directive?
a ☐ Yes b ☐ No

14 Who referred you to the physical therapist:
_____

15 Employment/Work (Job/School/Play)
a ☐ Working full-time outside of home
b ☐ Working part-time outside of home
c ☐ Working full-time from home
d ☐ Working part-time from home
e ☐ Homemaker f ☐ Student g ☐ Retired h ☐ Unemployed

i Occupation: _____

## LIVING ENVIRONMENT

16 Does your home have:
a ☐ Stairs, no railing
b ☐ Stairs, railing
c ☐ Ramps
d ☐ Elevator
e ☐ Uneven terrain
f ☐ Assistive devices (eg, bathroom): _____
g ☐ Any obstacles: _____

17 Do you use:
a ☐ Cane
b ☐ Walker or rollator
c ☐ Manual wheelchair
d ☐ Motorized wheelchair
e ☐ Glasses, hearing aids
f ☐ Other: _____

18 Where do you live?
a ☐ Private home
b ☐ Private apartment
c ☐ Rented room
d ☐ Board and care / assisted living / group home
e ☐ Homeless (with or without shelter)
f ☐ Long-term care facility (nursing home)
g ☐ Hospice
h ☐ Other: _____

19 GENERAL HEALTH STATUS
a Please rate your health:
(1) ☐ Excellent (2) ☐ Good (3) ☐ Fair (4) ☐ Poor

b Have you had any major life changes during past year? (eg, new baby, job change, death of a family member) (1) ☐ Yes (2) ☐ No

20 SOCIAL/HEALTH HABITS
a Smoking
(1) Currently smoke tobacco? (a) ☐ Yes 1. ☐ Cigarettes # of packs per day __
2. ☐ Cigars/Pipes # per day __
(b) ☐ No

(2) Smoked in past? (a) ☐ Yes Year quit: ☐☐☐☐ (b) ☐ No

b Alcohol
(1) How many days per week do you drink beer, wine, or other alcoholic beverages, on average? ___
(2) If one beer, one glass of wine, or one cocktail equals one drink, how many drinks do you have, on an average day? ___

c Exercise
Do you exercise beyond normal daily activities and chores?
(a) ☐ Yes Describe the exercise: _____
1. On average, how many days per week do you exercise or do physical activity? _____
2. For how many minutes, on an average day? ____
(b) ☐ No

21 FAMILY HISTORY (Indicate whether mother, father, brother/sister, aunt/uncle, or grandmother/grandfather, and age of onset if known)
a Heart disease: _____
b Hypertension: _____
c Stroke: _____
d Diabetes: _____
e Cancer: _____
f Psychological: _____
g Arthritis: _____
h Osteoporosis: _____
i Other: _____

## 22 MEDICAL/SURGICAL HISTORY

a Please check if you have ever had:

(1) ☐ Arthritis
(2) ☐ Broken bones/ fractures
(3) ☐ Osteoporosis
(4) ☐ Blood disorders
(5) ☐ Circulation/vascular problems
(6) ☐ Heart problems
(7) ☐ High blood pressure
(8) ☐ Lung problems
(9) ☐ Stroke
(10) ☐ Diabetes/ high blood sugar
(11) ☐ Low blood sugar/ hypoglycemia
(12) ☐ Head injury
(13) ☐ Multiple sclerosis
(14) ☐ Muscular dystrophy
(15) ☐ Parkinson disease
(16) ☐ Seizures/epilepsy
(17) ☐ Allergies
(18) ☐ Developmental or growth problems
(19) ☐ Thyroid problems
(20) ☐ Cancer
(21) ☐ Infectious disease (eg, tuberculosis, hepatitis)
(22) ☐ Kidney problems
(23) ☐ Repeated infections
(24) ☐ Ulcers/stomach problems
(25) ☐ Skin diseases
(26) ☐ Depression
(27) ☐ Other:_____

b Within the past year, have you had any of the following symptoms? (Check all that apply.)

(1) ☐ Chest pain
(2) ☐ Heart palpitations
(3) ☐ Cough
(4) ☐ Hoarseness
(5) ☐ Shortness of breath
(6) ☐ Dizziness or blackouts
(7) ☐ Coordination problems
(8) ☐ Weakness in arms or legs
(9) ☐ Loss of balance
(10) ☐ Difficulty walking
(11) ☐ Joint pain or swelling
(12) ☐ Pain at night
(13) ☐ Difficulty sleeping
(14) ☐ Loss of appetite
(15) ☐ Nausea/vomiting
(16) ☐ Difficulty swallowing
(17) ☐ Bowel problems
(18) ☐ Weight loss/gain
(19) ☐ Urinary problems
(20) ☐ Fever/chills/sweats
(21) ☐ Headaches
(22) ☐ Hearing problems
(23) ☐ Vision problems
(24) ☐ Other:_____

c Have you ever had surgery? (1) ☐ Yes (2) ☐ No
If yes, please describe, and include dates:

| | Month | Year |
|---|---|---|
| _____ | ☐☐ | ☐☐☐☐ |
| _____ | ☐☐ | ☐☐☐☐ |
| _____ | ☐☐ | ☐☐☐☐ |

**For men only:** d Have you been diagnosed with prostate disease?
(1) ☐ Yes (2) ☐ No

**For women only:**
Have you been diagnosed with:

e Pelvic inflammatory disease?
(1) ☐ Yes (2) ☐ No

f Endometriosis?
(1) ☐ Yes (2) ☐ No

g Trouble with your period?
(1) ☐ Yes (2) ☐ No

h Complicated pregnancies or deliveries?
(1) ☐ Yes (2) ☐ No

i Pregnant, or think you might be pregnant?
(1) ☐ Yes (2) ☐ No

j Other gynecological or obstetrical difficulties?
(1) ☐ Yes (2) ☐ No
If yes, please describe:
_____

## 23 CURRENT CONDITION(S)/CHIEF COMPLAINT(S)

a Describe the problem(s) for which you seek physical therapy
_____
_____

b When did the problem(s) begin (date)? Month ☐☐ Year ☐☐☐☐

c What happened?_____
_____

d Have you ever had the problem(s) before?
(1) ☐ Yes
(a) What did you do for the problem(s)? _____
_____
(b) Did the problem(s) get better?
1. ☐ Yes 2. ☐ No
(c) About how long did the problem(s) last? _____
(2) ☐ No

## 23 Current Condition(s)/Chief Complaint(s) (continued)

e How are you taking care of the problem(s) now? _____
_____

f What makes the problem(s) better? _____
_____

g What makes the problem(s) worse? _____
_____
_____

h What are your goals for physical therapy? _____
_____

i Are you seeing anyone else for the problem(s)? (Check all that apply.)

(1) ☐ Acupuncturist
(2) ☐ Cardiologist
(3) ☐ Chiropractor
(4) ☐ Dentist
(5) ☐ Family practitioner
(6) ☐ Internist
(7) ☐ Massage therapist
(8) ☐ Neurologist
(9) ☐ Obstetrician/gynecologist
(10) ☐ Occupational therapist
(11) ☐ Orthopedist
(12) ☐ Osteopath
(13) ☐ Pediatrician
(14) ☐ Podiatrist
(15) ☐ Primary care physician
(16) ☐ Rheumatologist
Other: _____

## 24 FUNCTIONAL STATUS/ACTIVITY LEVEL (Check all that apply.)

a ☐ Difficulty with locomotion/movement:
(1) ☐ bed mobility
(2) ☐ transfers (such as moving from bed to chair, from bed to commode)
(3) ☐ gait (walking)
(a) ☐ on level (c) ☐ on ramps
(b) ☐ on stairs (d) ☐ on uneven terrain

b ☐ Difficulty with self-care (such as bathing, dressing, eating, toileting)

c ☐ Difficulty with home management (such as household chores, shopping, driving/transportation, care of dependents)

d ☐ Difficulty with community and work activities/integration
(1) ☐ work/school
(2) ☐ recreation or play activity

## 25 MEDICATIONS

a Do you take any prescription medications? (1) ☐ Yes (2) ☐ No
If yes, please list:_____
_____

b Do you take any nonprescription medications? (Check all that apply.)

(1) ☐ Advil/Aleve
(2) ☐ Antacids
(3) ☐ Ibuprofen/ Naproxen
(4) ☐ Antihistamines
(5) ☐ Aspirin
(6) ☐ Decongestants
(7) ☐ Herbal supplements
(8) ☐ Tylenol
(9) ☐ Other: _____
_____
_____

c Have you taken any medications previously for the condition for which you are seeing the physical therapist?
(1) ☐ Yes (2) ☐ No If yes, please list:
_____

## 26 OTHER CLINICAL TESTS—Within the past year, have you had any of the following tests? (Check all that apply.)

a ☐ Angiogram
b ☐ Arthroscopy
c ☐ Biopsy
d ☐ Blood tests
e ☐ Bone scan
f ☐ Bronchoscopy
g ☐ CT scan
h ☐ Doppler ultrasound
i ☐ Echocardiogram
j ☐ EEG (electroencephalogram)
k ☐ EKG (electrocardiogram)
l ☐ EMG (electromyogram)
m ☐ Mammogram
n ☐ MRI
o ☐ Myelogram
p ☐ NCV (nerve conduction velocity)
q ☐ Pap smear
r ☐ Pulmonary function test
s ☐ Spinal tap
t ☐ Stool tests
u ☐ Stress test (eg, treadmill, bicycle)
v ☐ Urine tests
x ☐ X-rays
y ☐ Other:_____