BREAKTHRU PHYSICAL THERAPY & FITNESS

Background Information and Medical History Form

Name: _____ Date: _____

History of Current Problem(s) **Month/Date (if known)/Year**

When did the problem(s) begin (date)? _____

What happened? _____

Have you ever had the problem(s) before? _____

□Yes

Did the problem(s) get better? □Yes □No

About how long did it last? _____

□No

How are you taking care of the problem now? _____

What makes the problem(s) worse? _____

What activities are you not able to do now that you could do before the problem?
(Please be as specific as you can; for instance, "unable to reach over my head".)

_____

What are your goals for therapy? _____

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

□ Acupuncturist	□Osteopath	□Internist	□Podiatrist
□Cardiologist	□Dentist	□Neurologist	□Massage Therapist
□Orthopedist	□Pediatrician	□OBGYN	□Occupational Therapist
□Chiropractor	□Family Practitioner	□Rheumatologist	□Other_____

Current Limitation (Check all that apply):

□Difficulty with locomotion/movement:

□Bed mobility

□Transfers (such as moving from the bed to a chair, bed to commode)

□Gait (walking): □on level □stairs □ramps □uneven terrain

□Difficulty with self-care (bathing, dressing, eating, toileting)

□Difficulty with home management (household chores, shopping, driving)

□Difficulty with community and work activities

□Difficulty with recreation/sports

Employment:

Occupation:_____

□full time □part time □full duty/modified duty

□Currently not working due to: □injury/surgery □other_____

Home Environment:

What type of home do you live in?

□One floor/story □More than 1story: □ stairs with railing □without railing □Elevator

With whom do you live?

□Alone □Spouse only □Family members □Other?_____

Medications:

Please list all prescription medications_____

_____

_____

Please list all over- the counter medications: _____

_____

_____

_____ **Background Information and Medical History Form**

Medical History: Please check if you have ever had:

□Allergies
□Arthritis
□Blood disorders
□Broken bones
□Cancer
□Circulation/vascular issues
□Depression
□Diabetes/high blood sugar
□Developmental or growth problems
□Head injury
□Heart problems
□Hearing Loss
□High Blood Pressure
□Lung Issues
□Multiple sclerosis
□Kidney problems
□Low Blood Sugar/Hypoglycemia
□Infectious Disease (such as tuberculosis, hepatitis)
□Muscular dystrophy
□Osteoporosis
□Parkinson's Disease
□Repeated Infections
□Seizures/epilepsy
□Skin Diseases
□Stroke
□Thyroid Problems
□Ulcers/stomach problems
□Alcohol/Drug Dependency

□Height_____ □Weight_____

Other: _____

Surgeries: Please list any surgeries (including year):

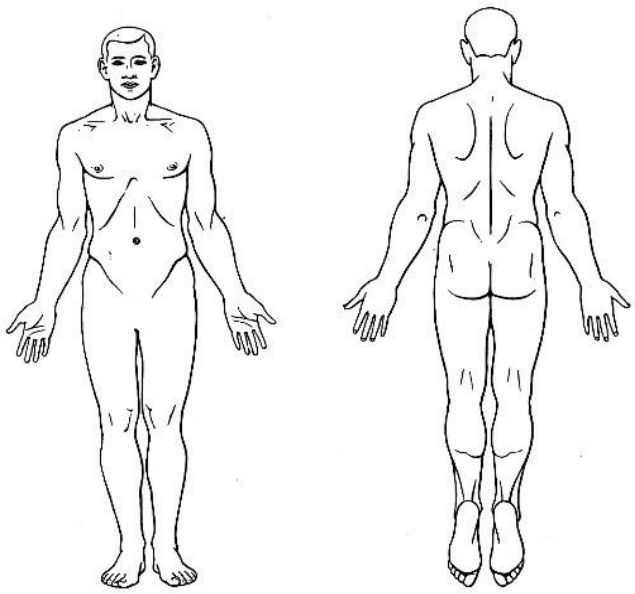
_____

_____

_____

Use the following drawing to indicate the location of your present symptoms. Use the symbols to describe the symptoms

Sharp Pain	Achiness	Burning	Pins and Needles	Numbness
/////	XXXX	!!!!!	00000	+++++



Instructions: Rate your major area of pain on the 0 – 10 Pain Rating Scale below:

_____

0 1 2 3 4 5 6 7 8 9 10

No pain Weak Moderate Strong Very Strong Maximal Pain

With Activity_____ At Rest_____