LCHD Physical Therapy and Fitness Center
History and Systems Review

Today's Date: _____

1 **Name:**

_____
Last

_____
First M.I. Jr./Sr.

2. **Street Address:** _____

_____
City State Zip

Phone Number: (___)_____
EMAIL:_____

3. **Date of Birth:** _____ _____ _____ **Age:** ____ years

4. **Sex:** ___Male ___Female

5. **Are you:** ___Right-handed ___Left-handed ___Unknown

6. **Type of Insurance:** Insurer _____
___Worker's Comp ___Medicare ___Self-pay ___Other

7. **Race**
___Asian
___Native Hawaiian/ Pacific Islander
___Black
___White

8. **Ethnicity**
___Hispanic or Latino
___Not Hispanic or Latino

9. **Language**
___English understood?
___Interpreter needed?
Language you speak most often:_____

10. **Education**
Highest grade completed (Circle one): 1 2 3 4 5 6 7 8 9 10 11 12
___Some college/technical school
___College graduate
___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?**
___Alone
___Spouse only
___Spouse and other(s)
___Child (not spouse)
___Other relative(s) (not spouse or children)
___Group setting
___Personal care attendant
___Other:

13. **Have you completed an advance directive?**
___Yes ___No

14. **Referring Physician/Other**: _____
Family Dr.:_____

15. **Employment/Work (Job/School/Play)**
___Working full-time outside of home
___Working part-time outside of home
___Working full-time from home
___Working part-time from home
___Homemaker ___Student ___Retired ___Unemployed

Occupation:_____

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LIVING ENVIRONMENT

16. **Does your home have:**
___Stairs, no railing
___Stairs, railing
___Ramps
___Elevator
___Uneven terrain
___Assistive devices (e.g., bathroom): _____
___Any obstacles: _____

17. **Do you use:**
___Cane
___Walker or rollator
___Manual wheelchair
___Motorized wheelchair
___Glasses, hearing aids
___Other: _____
_____

18. **Where do you live?**
___Private home
___Private apartment
___Rented room
___Board and care/assisted living/group home
___Homeless (with or without shelter)
___Long-term care facility (nursing home)
___Hospice
___Other: _____
_____

19. **GENERAL HEALTH STATUS**
Please rate your health:
___Excellent ___Good ___Fair ___Poor

Have you had any major life changes during the past year (e.g., new baby, job change, death of a family member)? ___Yes ___No

20. **SOCIAL/HEALTH HABITS**
Smoking
Currently smoke tobacco? ___Yes___No
___Cigarettes # of packs per day ___
___Cigars/Pipes # of packs per day ___

Smoked in past? ___Yes Year quit: _____ ___No

Alcohol: Chemical dependency? Yes _____ No _____
How many days per week do you drink beer, wine, or other alcoholic beverages, on average? _____

If one beer, one glass of wine, or one cocktail equals one drink, how many drinks do you have, on an average day? _____

Leisure/Exercise
Do you exercise beyond normal daily activities and chores?
___Yes ___No
Describe the exercise: _____
_____
On average, how many days per week do you exercise or do physical activity?_____
For how many minutes, on an average day? _____

21. **FAMILY HISTORY** (Indicate whether mother, father, brother/sister, aunt/uncle, or grandmother/grandfather, and age of onset if known)
Heart disease: _____
High Blood Pressure/ Hypertension: _____
Stroke: _____
Diabetes: _____
Cancer: _____
Depression/ Psychological issues: _____
Arthritis: _____
Osteoporosis: _____
Thyroid Problems_____
Tuberculosis _____
Blood Clots _____
Other: _____

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22. **MEDICAL/SURGICAL HISTORY**

Please check if you have ever had:

___Arthritis
___Rheumatoid Arthritis
___Degenerative Arthritis
___Broken bones/ fractures
___Osteoporosis
___Stroke
___Blood disorders
___Blood Clots
___Anemia
___Circulation/vascular problems
___Heart problems
___Pacemaker
___Chest pain/angina
___High blood pressure
___Diabetes/ High blood sugar
___Low blood sugar/ Hypoglycemia
___Head injury
___Multiple sclerosis
___Muscular dystrophy
___Parkinson disease
___Seizures/epilepsy
___Lung problems
___Asthma
___Thyroid problems
___Cancer
___Infectious disease (e.g., tuberculosis, hepatitis)
___Developmental or growth problems
___Kidney problems
___Repeated infections
___Ulcers/stomach problems
___Skin diseases
___Depression
___Other: _____

Are you latex sensitive? ___Yes ___No

___Allergies (meds, food, weather, tape etc) _____

_____

Within the past year or recently, have you had any of the following **symptoms**? (check one)

___Chest pain
___Heart palpitations
___Cough
___Hoarseness
___Shortness of breath
___Dizziness or blackouts
___Weakness in arms or legs
___Coordination problems
___Loss of balance/ falls
___Difficulty walking
___Joint pain or swelling
___Pain at night
___Numbness /tingling
___Fatigue
___Difficulty sleeping
___Loss of appetite
___Nausea/vomiting
___Difficulty swallowing
___Bowel problems
___diarrhea
___constipation
___Weight loss/gain
___Changes in bladder function
___Urinary problems (leakage)
___Fever/chills/sweats
___Headaches
___Hearing problems
___Vision problems
___Other: _____

Have you ever had **surgery**? ___Yes ___No

If yes, please describe, and include dates:

_____ _____ Month _____ Year

_____ _____ Month _____ Year

_____ _____ Month _____ Year

23. Have you ever had physical therapy before: ___Yes ___No

If yes, for what? _____

For men only: Have you been diagnosed with prostate disease?

___Yes ___No

For women only:

Have you been diagnosed with:

Pelvic inflammatory disease?	___Yes	___No
Endometriosis?	___Yes	___No
Trouble with your period?	___Yes	___No
Complicated pregnancies or deliveries?	___Yes	___No
Pregnant, or think you might be pregnant?	___Yes	___No
Other gynecological or obstetrical difficulties?	___Yes	___No

If yes, please describe: _____

_____

24. **CURRENT CONDITION(S)/CHIEF COMPLAINT(S)**

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

_____

_____

When did the problem(s) begin (date)? ____ Month _____ Year

What happened? _____

_____

Have you ever had the problem(s) before? ___Yes _____ No

What did you do for the problem(s)? _____

_____

Any treatment for the past problem?(chiropractic care, physical therapy, injections, etc)_____

_____

Did the problem(s) get better? ___Yes ___No

About how long did the problem(s) last? _____

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

_____

What are your **goals for physical therapy**?_____

_____

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

___Acupuncturist
___Cardiologist
___Chiropractor
___Dentist
___Family practitioner
___Internist
___Massage therapist
___Neurologist
___Obstetrician/gynecologist
___Occupational therapist
___Orthopedist
___Osteopath
___Pediatrician
___Podiatrist
___Primary care physician
___Rheumatologist
___Other: _____

25. **MEDICATIONS**

Do you take any prescription medications? ___Yes ___No

If yes, please list (Include injections): _____

_____

_____

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

___Advil/Aleve
___Antacids
___Ibuprofen/ Naproxen
___Antihistamines
___Aspirin
___Decongestants
___Herbal supplements
___Tylenol
___Vitamins
___Skin Patches
___Other: _____

_____

Have you taken any **medications previously** for the condition for which you are seeing the physical therapist?

___Yes ___No

If yes, please list: _____

Have you ever taken **steroid medications** for any medical conditions?

___Yes ___No

Have your ever taken **blood thinning or anticoagulant** medications for an7y medical condition? ___Yes ___No

26. **OTHER CLINICAL TESTS**

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

___Angiogram
___Arthroscopy
___Biopsy
___Blood tests
___Bone scan
___Bronchoscopy
___CT scan
___Doppler ultrasound
___Echocardiogram
___EEG(electroencephalogram)
___EKG(electrocardiogram)
___EMG (electromyogram)
___Mammogram
___MRI
___Myelogram
___NCV (nerve conduction velocity)
___Pap smear
___Pulmonary function test
___Spinal tap
___Stool tests
___Stress test (e.g., treadmill, bicycle)
___Urine tests
___X-rays
___Other: _____

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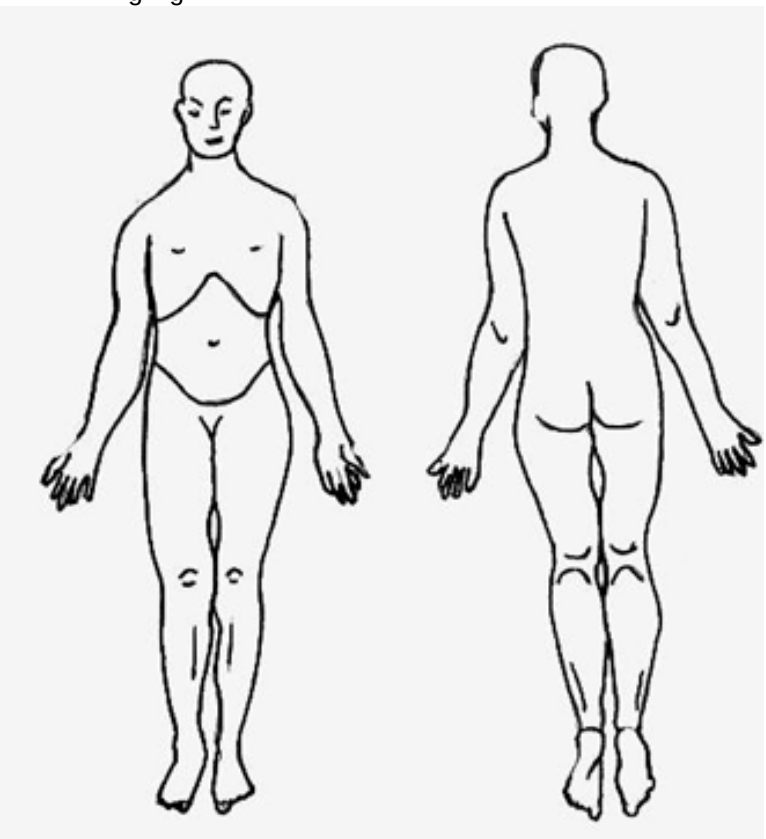
27. **FUNCTIONAL STATUS/ACTIVITY LEVEL** (Check all that apply.)
- ___**Difficulty with locomotion/movement:**
  - ___**bed mobility**
  - ___**transfers (such as moving from bed to chair, from bed to commode)**
  - ___**gait (walking)**
    - ___**on level** ___**on ramps**
    - ___**on stairs** ___**on uneven terrain**
- ___**Difficulty with self-care (such as bathing, dressing, eating, toileting)**
- ___**Difficulty with home management (such as household chores, shopping, driving/transportation, care of dependents)**
- ___**Difficulty with community and work activities/integration**
  - ___**work/school**
  - ___**recreation or play activity**

28. BODY CHART

Please mark the areas where you feel symptoms on the chart with the following symbols to describe your symptoms:
******* Sharp, shooting pain
//////// Dull/ aching pain
+++++ Numbness
- - - - - -Tingling



My symptoms (circle any that apply)
- ___Come and go
- ___Are Constant
- ___Are Constant and change with activity
- ___Are improving
- ___Are getting worse
- ___ Are not changing

Using the 0-10 scale,
with 0 = NO pain, and 10- Worst Pain Imaginable
please describe your pain:
Current level of pain while completing this survey:_____
Best pain over the past 30 days: _____
Worst pain over past 30 days: _____

Is your sleep interrupted by your symptoms at night?
- ___No problems sleeping
- ___difficulty falling asleep
- ___Awakened by pain
- ___Sleep only with medication

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

When are your symptoms **the best**?
- ___Morning
- ___Afternoon
- ___Evening
- ___ Night
- ___After Exercise

_____

When are your symptoms the **worse**?
- ___Morning
- ___Afternoon
- ___Evening
- ___ Night
- ___After Exercise

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

29. During the past month, have you been feeling down, depressed, or hopeless? ____Yes _____No
During the past month, have you been bothered by having little interest or pleasure in doing things? ____Yes ____No
Is this something with which you would like help? ____Yes _____No _____
Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? ____Yes _____ No

30. What is your preferred learning style?
___Pictures ___Reading
___Listening ___Demonstration
___Other: