Dee PT
integrated rehabilitation • therapy • fitness

Name:_____
DOB:_____Age:_____
Todays Date:_____
Chart #:_____

Client History Information

****Please fill out to the best of your ability and focus on what is pertinent to your visit with us today****

General Health Status

Please rate your health: __ Excellent __ Good __ Fair __ Poor
Exercise: __ None __Moderate __Daily __Heavy __Athlete
Health Habits: __ Smoking __Alcohol __Water __Coffee/Caffeine __Stress
Any Major Life Changes in the Last Year? (eg, new baby, job change, death in the family) __ Yes __No
If yes, please describe: _____

Family History

Please list if your father, mother, sibling, aunt/uncle or grandparent has had any of the following conditions and the age of onset if known.

Arthritis: _____ Cancer: _____
Diabetes: _____ Heart Disease: _____
Hypertension: _____ Osteoporosis: _____
Psychological: _____ Stroke: _____
Other: _____ Other: _____

Medical/Surgical History Please check if you have ever had:

__Arthritis __Heart Problems __Muscular Distrophy
__Asthma __High Blood Pressure __Osteoporosis
__Blood Disorders __High Cholesterol __Parkinsons
__Cancer __Infectious Disease (TB, Hepatitis) __Repeated Infections
__Circulation/Vascular Problems __Kidney Problems __Seizures/Epilepsy
__Depression __Low Blood Sugar/Hypoglycemia __Skin Disease
__Developmental/Growth Issues __Lung Problems __Stroke
__Diabetes/High Blood Sugar __Migraine Headaches __Thyroid Problems
__Head Injury __Multiple Sclerosis __Ulcers/Stomach Problems

Other: _____

Broken Bones/Fractures (include dates) Surgeries (include dates)
_____ __/__/__ _____ __/__/__
_____ __/__/__ _____ __/__/_

Allergies: _____
Supplements/Herbs: _____
_____
Medications: _____
_____

MEDICARE PATIENTS ONLY

Height* _____ Weight* _____
**Have you fallen 2 or more times in the past year? Yes / No
**In the past year, have you fallen and sustained an injury due to that fall? Yes / No

Turn Over

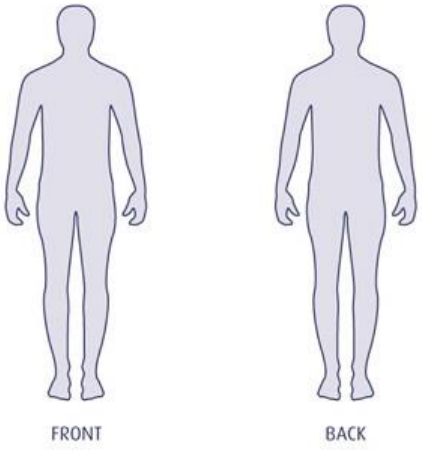
Employment/Recreation

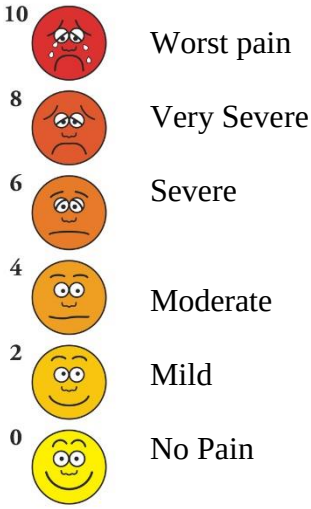
Are you: __A Student __Employed __Unemployed __ A Homemaker __Retired
Hobbies/Sports: _____
Current Employment: Occupation _____ __Part-time __Full-time
Work Activity: __ None __ Sitting __Standing __Light Labor __Heavy Labor
Out of Work Due to Injury?: __No __Yes, please describe: _____
Work Restrictions?: __No __Yes, please describe: _____

Current Condition/Chief Complaint

Reason for Visit: _____
Is this condition: ___A New Problem __A Chronic Problem __Unknown
When did symptoms appear?: _____ Is it getting worse?: __Yes __No __Unknown
What makes the problem(s) better?: _____
What makes the problem(s) worse?: _____
What are your goals for physical therapy?: _____

Please circle the location of your pain or where you may be having difficulty functioning, and circle your level of pain on the right.





Are you seeing anyone else for the problem(s)?: *Please check all that apply*

__Acupuncturist	__Cardiologist	__Chiropractor	__Dentist
__Family Practitioner	__Internist	__Massage Therapist	__Neurologist
__OBGYN	__OT	__Orthopedist	__Osteopath
__Pediatrician	__Podiatrist	__Primary Care Dr.	__Rheumatologist

__Other: _____

Is your problem(s) affecting your daily activities?: *Please check all that apply*

__Bed Mobility	__Walking	__Driving	__Recreation
__Shopping	__Household Care	__Dependent Care	__Self Care (bathing, dressing etc)

Patient/Guardian Signature: _____ Date: _____

Turn Over