

ALEXANDER SPRING REHAB, INC.
Patient History Form

Name: _____ Date: _____

Age: _____ Date of Birth: _____ Weight: _____ Height: _____

Where do you work? _____

What are your job duties? _____

Describe your physical problem (& when symptoms started): _____

Other related treatment (Ex: Chiropractic, prior PT - Describe): _____

Tests (X-rays, CT, MRI, bone scan) related to your current problem: _____

List major surgeries: _____

Hospitalizations (not for surgery): _____

What is your goal regarding PT treatment? _____

FUNCTIONAL STATUS: Do you have difficulty with any of the following? _____ Getting up from chair
 _____ Transfers _____ Walking/Gait _____ Self care _____ Getting in or out of bed, or _____ Car
 _____ Bathing _____ Dressing _____ Eating _____ Going up/down stairs _____ Driving
 _____ Shopping _____ Balance _____ Turning head _____ Dependent care _____ Reaching
 _____ Work/school _____ Recreation _____ Toileting _____ Household chores _____ Bending at waist
 _____ Sleep disturbance? Please describe: _____
 _____ Other: _____

Are your symptoms: Worsening _____ Improving _____ Staying the same _____

Assistive devices used (Please select): Crutches _____ Cane _____ Walker _____ Wheelchair _____
 Shower chair _____ Elevated toilet seat _____ Other _____

Do you live: With family or caregiver? _____ Alone? _____. If alone, do you have assistance? _____
 Do You Have to Use Stairs at Home (inside or out)? Describe: _____

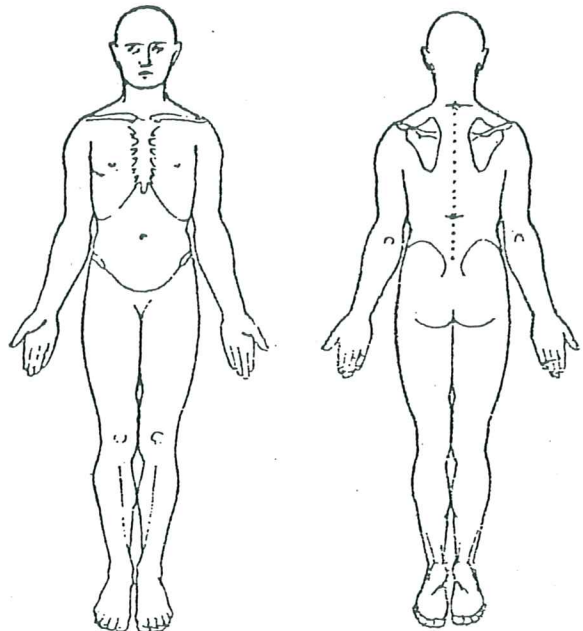
PLEASE RATE YOUR PAIN ON A SCALE OF 1 TO 10: Pain Level _____/10. "0" being no pain, "10" being the worst pain imaginable" (such that you would go to the ER).

PLEASE DESCRIBE:

- _____ Never goes away
- _____ Daily, or several times a week
- _____ Once a week
- _____ Less than once a week
- _____ Relieved with position, change, or rest
- _____ Sharp
- _____ Shooting
- _____ Burning
- _____ Dull
- _____ Throbbing
- _____ Pulling
- _____ Ache
- _____ Tingling
- _____ Numb
- _____ Heavy
- _____ Tight
- _____ Stabbing
- _____ Other _____

INDICATE YOUR CURRENT SYMPTOMS ON THE BODY DIAGRAM,

USING: xxx for pain symptoms, /// for numbness/tingling symptoms



PLEASE FILL OUT REVERSE:

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HAVE YOU OR ANY IMMEDIATE FAMILY MEMBER BEEN TOLD YOU HAVE :

	Self	Family		Self	Family
Cancer	_____	_____	Thyroid problems	_____	_____
High blood pressure	_____	_____	Heart disease/problem	_____	_____
High cholesterol	_____	_____	Angina/chest pain	_____	_____
Diabetes	_____	_____	Osteoporosis (thinning bones)	_____	_____
Arthritis	_____	_____	Tuberculosis	_____	_____
Stroke	_____	_____	COPD	_____	_____
Gerd	_____	_____			

DO YOU HAVE A HISTORY OF:

Allergies/asthma	_____	Headaches	_____	Seizures	_____	Bronchitis	_____
Kidney disease	_____	Rheumatic fever	_____	Hepatitis	_____	Ulcers	_____
Fibromyalgia	_____	Fractures	_____				

Other Medical History: _____

Date of Last Physical: _____

List of Medications: _____

Allergies: _____

IN THE PAST 3 MONTHS, HAVE YOU HAD OR DO YOU EXPERIENCE:

A change in your health	_____	Urinary tract infection	_____	Falls	_____
Fever/chills/sweats	_____	Change in bladder function	_____		
Numbness/tingling	_____	Change in bowel	_____		
Difficulty swallowing	_____	Nausea/vomiting	_____		
Shortness of breath	_____	Unexplained weight change	_____		
Dizziness	_____	Changes in appetite	_____		
Lightheadedness	_____	Upper respiratory infection	_____		

ARE YOU CURRENTLY?

Pregnant?	_____	DO YOU HAVE		DO YOU HAVE	
Depressed?	_____	Pacemaker?	_____	Metal implants?	_____
Under stress?	_____	Defibrillator?	_____	Hearing Aids?	_____
		Corrective Lenses?	_____		

Do you or have you smoked tobacco? *Yes _____ No _____ *Packs per day _____ x _____ years

If you have quit, last tobacco use & amount: _____

Alcohol usage/frequency: _____

Do you have any problems for which you'd like to speak to a social worker? Yes _____ No _____