TherapeuticAssociates
PHYSICAL THERAPY

To save time in your registration process, please fill out and print this form and bring it with you to the clinic for your appointment. If unable, you will be able to fill out the form when you arrive for your appointment.

NAME:______________________ DATE:______________

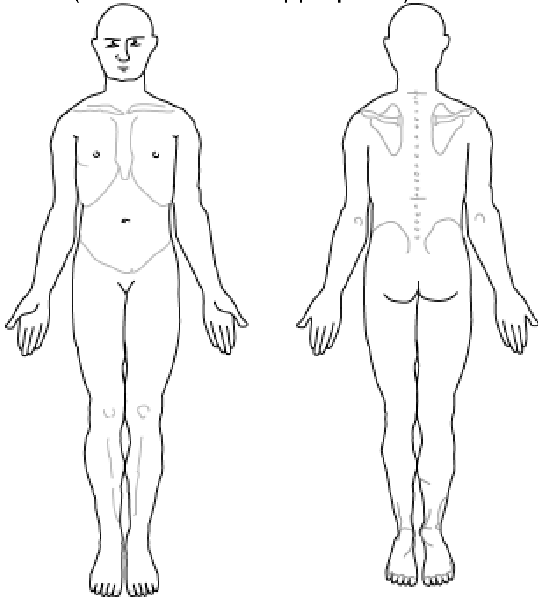
HISTORY OF PRESENT CONDITION

To insure that you receive a complete and thorough evaluation, please provide us with important background information on the following form. If you do not understand the question, your therapist will assist you. Thank you.

1) Reason for visit? ________________________________

____

Localize areas of **pain** or **abnormal** sensation on the body chart below (shade in where appropriate)



2) When did your symptoms begin? ____________
(Please indicate a specific date if possible)

3) Was the **onset/timing** of this episode?
❒ gradual ❒ sudden
Any previous episodes ❒ Yes ❒ No

4) Which of the following best describes how your injury occurred? *(If you condition is post-surgical, please indicate as per original injury)*
❒ unknown ❒ degenerative process
❒ while Lifting ❒ an incident at work
❒ MVA (car accident) ❒ dental appointment
❒ a fall ❒ during recreation/sports
❒ trauma ❒ overuse (cumulative trauma)
❒ other________________________

5) Since the onset, are your symptoms? (Check one)
❒ improving ❒ not changing ❒ worsening

6) Have you had any fall(s) in the past year? ❒ No
❒ Yes, how many times _____ ; ❒ injured ❒ not injured

7) Nature of pain/symptoms (check all that apply)
❒ sharp ❒ aching ❒ constant
❒ dull ❒ periodic ❒ other___________
❒ throbbing ❒ occasional

As the day progresses, do your symptoms: (Check one)
❒ increase ❒ decrease ❒ stay the same

Does the pain wake you at night?
❒ No ❒ Yes If "yes", is it present
❒ while lying down ❒ only when changing positions
❒ both

Do you have pain/stiffness upon getting out of bed in the morning? ❒ Yes ❒ No

8) In what position do you sleep? (Check all that apply)
❒ back, sides, stomach ❒ right side
❒ left side ❒ on stomach
❒ on back ❒ chair/recliner

9) Since the onset of your current symptoms have you had: (Check all that apply)
❒ any difficulty with bowel or bladder function
❒ fever/chills
❒ numbness in the genitals or anal area
❒ numbness
❒ any dizziness or fainting
❒ unexplained weakness
❒ unexplained weight change
❒ night pain/sweats
❒ malaise (vague feeling of bodily discomfort
❒ problems with vision/hearing
❒ none of the above

10) What aggravates your symptoms? (Check all that apply)
❒ sitting ❒ going to/rising from sitting
❒ walking ❒ up/down stairs
❒ standing ❒ squatting
❒ lying down ❒ sleeping
❒ looking up overhead ❒ sustained bending
❒ reaching overhead ❒ reaching in front of body
❒ reaching behind back ❒ reaching across body
❒ repetitive activity ____________________________
❒ household activity ____________________________
❒ recreation/sports including ______________________
❒ coughing/sneezing ❒ taking a deep breath
❒ talking ❒ chewing ❒ yawning ❒ swallowing
❒ stress

11) What relieves your symptoms? (Check all that apply)
❒ nothing ❒ medication ❒ wearing splint/orthosis
❒ rest ❒ cold ❒ heat
❒ sitting ❒ standing ❒ walking ❒ lying down
❒ stretching ❒ exercise ❒ massage

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You may fill out the following questions on our Patient Portal visit http://www.therapeuticassociates.com to get started. Otherwise please complete and bring in for your first appointment.

MEDICATIONS

❒ Consent for Electronic Download of Medication History.
Or
Please list any prescription medications you are currently taking (*pain pills, injections and/or skin patches, etc.*):

____

____

Are you currently taking any of the following over the counter medications?

❒ aspirin ❒ Advil/Motrin/Ibuprofen
❒ Tylenol ❒ corticosteroids
❒ antihistamines ❒ vitamins/mineral supplements
❒ other______________________________________

OCCUPATION INFORMATION

Occupation________________________________

❒ employed full time ❒ student
❒ employed part time ❒ retired
❒ self employed ❒ unemployed
❒ homemaker ❒ other____________

Physical activities at work? __________________________

____

Are you currently receiving or seeking disability for this condition? ❒ Yes ❒ No

If not performing your normal activities at work do you plan to RETURN to your previous activity level? ❒ Yes ❒ No

LIVING ENVIRONMENT

❒ live alone ❒ live with others
❒ home/apartment ❒ retirement complex (SNF/ICF)
❒ assisted living complex

❒ stairs (railing) ❒ no stairs ❒ uneven ground
❒ stairs (no railing) ❒ ramp ❒ elevator
❒ other ________________________________

GENERAL HEALTH

How would you rate your general health?

❒ Excellent ❒ Average ❒ Poor
❒ Good ❒ Fair

Previous Functional Level

❒ **Independent in all activities** (work, community, home, recreation)
❒ Independent in all self-care activities (bathing, toileting, dressing, etc.)
❒ Difficulty performing self-care activities
❒ Needed assistance with self-care activities
❒ Difficulty performing household chores
❒ Difficulty with activities in community outside of home

Do you exercise outside of normal daily activities?

❒ 5+ days/wk ❒ 3-4 days/wk ❒ 1-2 days/wk
❒ occasionally ❒ zero

Exercise, Sports/Recreation consisting of ________________

____

What is your general stress level?

❒ Low ❒ Medium ❒ High

Caffeinate Intake?

❒ None ❒ Occasional ❒ Moderate ❒ Heavy

Alcohol Intake?

❒ None ❒ Occasional ❒ Moderate ❒ Heavy

Smoking Status?

❒ Never ❒ Former smoker ❒ Current every day
❒ Current some day smoker ❒ Unknown

If smoker how much? __________ ❒ Tobacco ❒ Marijuana

Are you seeing any health care providers other than the physical therapist for this current condition?
(Please list)____

MEDICAL HISTORY

Have you ever had/been diagnosed with any of the following conditions? (Check all that apply)

❒ No diseases or conditions

❒ Cancer ❒ Arthritis
❒ Depression ❒ Osteoporosis
❒ Diabetes ❒ Dental Problems
❒ Circulation/Vascular Problems ❒ Headaches/Migraines
❒ Stroke ❒ Hepatitis
❒ Heart Problems ❒ HIV or AIDS
❒ Pacemaker ❒ Kidney Problems
❒ High Blood Pressure ❒ Lung Problems
❒ Muscle, Joint, or Bone Problems ❒ Stomach Problems

SURGICAL/TESTS HISTORY

❒ No surgeries

Type/Date *Type/Date*

❒ Shoulder Surgery ______ ❒ Hip Surgery ______
❒ Knee Surgery ______ ❒ Achilles Tendon Repair ______
❒ ACL Reconstruction ______ ❒ Heart Surgery ______
❒ Back Surgery ______ ❒ Hip Surgery ______
❒ Joint Replacement ______ ❒ Elbow Surgery ______
❒ Ankle/Foot Surgery ______ ❒ Neck Surgery______

Other:____

Other:____

Have you had any of the following tests?

❒ none ❒ Bone Scan ❒ Vestibular
❒ x-rays ❒ Arthrogram ❒ Stress X-ray Test
❒ CT Scan ❒ MRI

FAMILY HISTORY

❒ No diseases or conditions

Medical Condition	*relation/onset age if known*
❒ Diabetes	________
❒ Alzheimer's	________
❒ Heart disease	________
❒ Cancer	________
❒ Stroke/CVA	________
❒ Arthritis	________
❒ Rheumatoid arthritis	________
❒ Asthma	________
❒ Musculoskeletal disease	________
❒ Skin disorder	________
❒ Osteoporosis	________
❒ Mental disorder	

❒ Other: ________________________________

Acknowledgement of Privacy Practice Notice

TherapeuticAssociates
PHYSICAL THERAPY

(To be retained by Medical Provider)

Revision Date: October 23, 2018

Respect for our patient's privacy has long been highly valued at Therapeutic Associates. Not only is it what our patients expect, it's the right way to conduct healthcare. As required by law, we will protect the privacy of health information that may reveal your identity and provide you with a copy of our Notice of Privacy Practices. This is available on our website at https://www.therapeuticassociates.com/privacy-policy/ or printed for you on request.

I understand that Therapeutic Associates (referred to below as "the clinic") will use and disclose health information about me in the course of providing physical therapy care to me.

I understand that my health information may include information both created and received by the clinic, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand that the clinic is permitted to use and disclose my health information in order to:

- Make decisions about and plan for my care and treatment;
- Refer to, consult and coordinate with other health care providers in the course of my treatment;
- Determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- Perform various office, administrative and business functions that support the clinic's ability to provide me with appropriate care and arrange for payment.

I also understand that I have the right to receive a written Notice of Privacy Practices which describes how the clinic uses and discloses health information, the information practices followed by the clinic staff and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time and that I am entitled to receive a copy of any revised Notice of Privacy Practices upon request.

By signing below, I agree that I have reviewed and understand the information above and that I have received or can access a copy of the Notice of Privacy Practices.

By: ____________________________________ Date: ____________________________________

(Patient)

-OR-

By: ____________________________________ Date: ____________________________________

(Patient Representative) Description of Representative's Authority: ______________________________