

# A Step Ahead Physical Therapy

## PHYSICAL THERAPY ASSESSMENT

### PHYSICAL THERAPY PATIENT/CLIENT MANAGEMENT

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_

Last

First

MI

Jr/Sr

Height \_\_\_\_\_

Weight \_\_\_\_\_

Age \_\_\_\_\_

Blood Pressure at last doctor's visit: \_\_\_\_\_

Are you: ( ) Righthanded ( ) Lefthanded

**Cultural / Religious:** Any customs or religious beliefs or wishes that might affect care? \_\_\_\_\_

#### Education:

Highest grade completed (circle one): 1 2 3 4 5 6 7 8 9 10 11 12

\_\_\_ Some college/ technical school

\_\_\_ College school / advance degree

\_\_\_ Graduate School/Advance Degree

#### Employment:

\_\_\_ 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: \_\_\_\_\_

Who referred you to Physical Therapy: \_\_\_\_\_

Date of last visit to Referring Physician: \_\_\_\_\_

#### Where do you live?

\_\_\_ Private home

\_\_\_ Private apartment

\_\_\_ Rented room

\_\_\_ Hospice

\_\_\_ Board and care/assisted living/group home

\_\_\_ Homeless(with or without shelter)

\_\_\_ Long-term care facility(nursing home)

Other: \_\_\_\_\_

#### With whom do you live?

\_\_\_ Alone

\_\_\_ Spouse only

\_\_\_ Spouse and others

\_\_\_ Child(not spouse)

\_\_\_ Other relative(s) (not spouse  
or children)

\_\_\_ Personal care attendant

\_\_\_ Group setting

Other: \_\_\_\_\_

#### Does your home have:

\_\_\_ Stairs, no railing

\_\_\_ Stairs, w/railing

\_\_\_ Ramps

\_\_\_ Elevator

\_\_\_ Uneven Terrain

\_\_\_ Other Obstacles: \_\_\_\_\_

#### Do you use:

\_\_\_ Cane

\_\_\_ Walker or rollator

\_\_\_ Manual Wheelchair

\_\_\_ Motorized wheelchair

\_\_\_ Other \_\_\_\_\_

Please rate your health:

\_\_\_ Excellent \_\_\_ Good \_\_\_ Fair \_\_\_ Poor

Have you had any major life changes during the past Year? (such as a new baby, job change, death of a family member)

\_\_\_ Yes \_\_\_ No

#### Health Habits

Do you exercise regularly? \_\_\_ Yes \_\_\_ No

If yes, how often and what type of activities?  
\_\_\_\_\_

Do you use tobacco products? \_\_\_ Yes \_\_\_ No

Typed used? \_\_\_\_\_

If no, have you used tobacco products in the past?

\_\_\_ Yes \_\_\_ No Year Quit: \_\_\_\_\_

How many days per week do you drink beer, wine, or other alcoholic beverages, on average? \_\_\_\_\_

Family History (indicate whether mother, father, brother/sister, aunt/uncle, or grandmother/grandfather had any of the following disorders and provide age of onset if known)

Heart disease: \_\_\_\_\_

Hypertension: \_\_\_\_\_

Stroke: \_\_\_\_\_

Diabetes: \_\_\_\_\_

Cancer: \_\_\_\_\_

Other: \_\_\_\_\_

#### Medications:

Do you take any prescription medications? \_\_\_ Yes \_\_\_ No

If yes, please list:

Medication	Dosage	Frequency
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\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Patient Provided List \_\_\_\_\_

PT Initial

#### Allergies:

Do you have any allergies? \_\_\_ Yes \_\_\_ No

If yes, please list: \_\_\_\_\_

Do you take any nonprescription medications or supplements?

\_\_\_ Yes \_\_\_ No

If yes, what? \_\_\_\_\_

#### General Health

Therapist Initials: \_\_\_\_\_

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Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_

#### Medical History Form & Medications Reviewed

Please check if you have ever had:

- |  |   |
|--|---|
| <input type="checkbox"/> Arthritis                           | <input type="checkbox"/> Infectious disease (such as tuberculosis, hepatitis) |
| <input type="checkbox"/> Blood disorders                     | <input type="checkbox"/> Kidney problems                                      |
| <input type="checkbox"/> Broken bones/fractures              | <input type="checkbox"/> Low blood sugar/hypoglycemia                         |
| <input type="checkbox"/> Cancer                              | <input type="checkbox"/> Lung problems  |
| <input type="checkbox"/> Circulation/vascular problems       | <input type="checkbox"/> Multiple sclerosis                                   |
| <input type="checkbox"/> Depression / Psychological problems | <input type="checkbox"/> Muscular dystrophy                                   |
| <input type="checkbox"/> Developmental or growth problems    | <input type="checkbox"/> Osteoporosis   |
| <input type="checkbox"/> Diabetes/high blood sugar           | <input type="checkbox"/> Parkinson's diseases                                 |
| <input type="checkbox"/> Eating or Nutritional Disorders     | <input type="checkbox"/> Repeated infections                                  |
| <input type="checkbox"/> Stroke                              | <input type="checkbox"/> Seizures/epilepsy                                    |
| <input type="checkbox"/> Thyroid problems                    | <input type="checkbox"/> Skin diseases  |
| <input type="checkbox"/> Ulcers/stomach problems             | <input type="checkbox"/> Head injury  |
|  | <input type="checkbox"/> Heart problems                                       |
|  | <input type="checkbox"/> High blood pressure                                  |
|  | <input type="checkbox"/> Other: _____   |

#### Within the past year have you had any of the following medical Tests:(Check all that apply)

- |   |   |
|---|---|
| <input type="checkbox"/> Angiogram                  | <input type="checkbox"/> Mammogram                            |
| <input type="checkbox"/> Arthroscopy                | <input type="checkbox"/> MRI                                  |
| <input type="checkbox"/> Biopsy                     | <input type="checkbox"/> Myelogram                            |
| <input type="checkbox"/> Blood test                 | <input type="checkbox"/> NCV (nerve conduction velocity)      |
| <input type="checkbox"/> Bone scan                  | <input type="checkbox"/> Pap smear                            |
| <input type="checkbox"/> Bronchoscopy               | <input type="checkbox"/> Pulmonary function test              |
| <input type="checkbox"/> CT scan                    | <input type="checkbox"/> Spinal tap                           |
| <input type="checkbox"/> Doppler ultrasound         | <input type="checkbox"/> Stool test                           |
| <input type="checkbox"/> Echocardiogram             | <input type="checkbox"/> Stress test (eg, treadmill, bicycle) |
| <input type="checkbox"/> EEG (electroencephalogram) | <input type="checkbox"/> Urine tests                          |
| <input type="checkbox"/> EKG (electrocardiogram)    | <input type="checkbox"/> X-rays                               |
| <input type="checkbox"/> EMG (electromyogram)       |   |

#### For Men:

Have you been diagnosed with prostate disease?  
 Yes  No

#### For Women:

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

Have you ever had surgery?  Yes  No

If yes, please describe, and include dates:

Month/Year

\_\_\_\_\_/\_\_\_\_\_  
\_\_\_\_\_/\_\_\_\_\_  
\_\_\_\_\_/\_\_\_\_\_  
\_\_\_\_\_/\_\_\_\_\_

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

- |   |   |
|---|---|
| <input type="checkbox"/> Bowel problems         | <input type="checkbox"/> Hoarseness               |
| <input type="checkbox"/> Chest pain             | <input type="checkbox"/> Joint pain or swelling   |
| <input type="checkbox"/> Coordination problems  | <input type="checkbox"/> Loss of appetite         |
| <input type="checkbox"/> Cough                  | <input type="checkbox"/> Loss of balance          |
| <input type="checkbox"/> Difficulty sleeping    | <input type="checkbox"/> Nausea/vomiting          |
| <input type="checkbox"/> Difficulty swallowing  | <input type="checkbox"/> Pain at night            |
| <input type="checkbox"/> Difficulty walking     | <input type="checkbox"/> Shortness of breath      |
| <input type="checkbox"/> Dizziness or blackouts | <input type="checkbox"/> Urinary problems         |
| <input type="checkbox"/> Fever/chills/ sweats   | <input type="checkbox"/> Vision problems          |
| <input type="checkbox"/> Headaches              | <input type="checkbox"/> Weakness in arms or legs |
| <input type="checkbox"/> Hearing problems       | <input type="checkbox"/> Weight loss/gain         |
| <input type="checkbox"/> Heart palpitations     |   |
| <input type="checkbox"/> Other: _____           |   |

#### Current Limitation (Check all that apply)

- Difficulty with bed mobility  
 Difficulty with transfers (such as moving from bed to chair, from bed to commode)  
 Difficulty walking  
 on level surface  on stairs  on ramps  
 on uneven terrain  
 Difficulty with self-care (such as bathing, dressing, eating, toileting)  
 Difficulty with home management (such as household chores, shopping, driving/transportation)  
 Difficulty with community and work activities/integration  
 Difficulty work/school  
 Difficulty recreation or play activity

#### History of Current Problem(s)

When did the problem(s) begin? \_\_\_\_/\_\_\_\_/\_\_\_\_

What happened?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you ever had the problem(s) before?

Yes  No

What did you do for the problem(s)?

\_\_\_\_\_  
\_\_\_\_\_

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 makes the problem(s) worse \_\_\_\_\_

\_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

Therapist Initials: \_\_\_\_\_

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Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_

What are your goals for physical therapy? \_\_\_\_\_

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

- |  |   |
|--|---|
| <input type="checkbox"/> Acupuncturist             | <input type="checkbox"/> Occupational therapist |
| <input type="checkbox"/> Cardiologist              | <input type="checkbox"/> Orthopedist            |
| <input type="checkbox"/> Chiropractor              | <input type="checkbox"/> Osteopath              |
| <input type="checkbox"/> Dentist                   | <input type="checkbox"/> Pediatrician           |
| <input type="checkbox"/> Family practitioner       | <input type="checkbox"/> Podiatrist             |
| <input type="checkbox"/> Internist                 | <input type="checkbox"/> Primary care physician |
| <input type="checkbox"/> Massage therapist         | <input type="checkbox"/> Rheumatologist         |
| <input type="checkbox"/> Neurologist               | <input type="checkbox"/> Other: _____           |
| <input type="checkbox"/> Obstetrician/Gynecologist | <input type="checkbox"/> Speech Therapist       |

It is important that we have a measure of your pain. Please rate the level of your pain on the following scale.

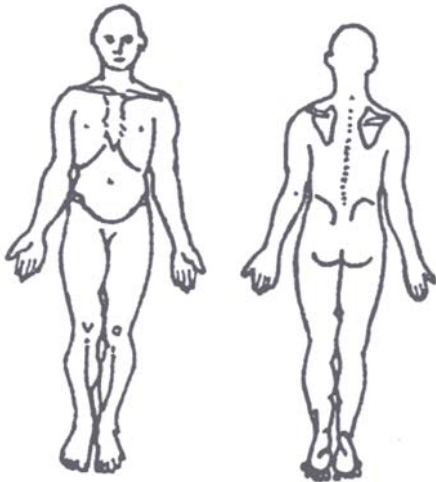
At present: 0 1 2 3 4 5 6 7 8 9 10

At best: 0 1 2 3 4 5 6 7 8 9 10

At worst: 0 1 2 3 4 5 6 7 8 9 10

(no pain) (moderate pain) (extreme agony)

Please indicate painful areas by shading these models.



Which of these words describe your pain? (Circle all that apply)

Sharp Dull Burning Aching Tingling

Numb Constant Variable Radiating (moves)

**Therapist Initials:** \_\_\_\_\_