

For office use only

OJI

MVA

Diagnosis _____

Code(s) _____

Referring Physician _____

Acct. # _____

Claim # _____

STAR PHYSICAL THERAPY PATIENT PROFILE QUESTIONNAIRE

Please fill out this form as completely as possible. This will assist your therapist in developing a safe and appropriate treatment for you. We appreciate your input!

Today's Date _____

Name _____ Date of Birth _____ Age _____ Height _____ Weight _____

What is your primary problem? _____

When and how did your problem begin? _____

Surgery for this condition?: Yes No Date of surgery ___/___/___ Type of surgery _____

Diagnostic testing (check all that apply) None X-Ray MRI CT Scan EMG

NCV Bone Scan Other: _____ Results if known _____

Are your symptoms: Improving Worsening Staying the same?

Have you had any previous treatment? Physical Therapy Massage Therapy Injection Chiropractic

Pain Clinic Acupuncture Other: _____

Are your symptoms? Constant Comes and goes daily Occasional (less than daily) Sporadic (less than weekly)

Symptom Description: Aching Stabbing Burning Dull Steady Throbbing Numbness/Tingling

What activities make you feel better? _____

What activities make you feel worse? _____

Can you get comfortable at night? Yes No

Does time of day affect your symptoms? Yes No

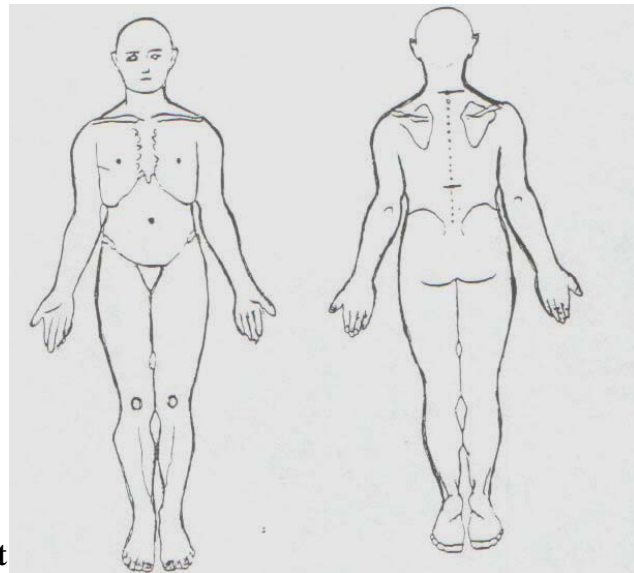
What is your occupation? _____

Are you presently working? Yes No

No pain 0 1 2 3 4 5 6 7 8 9 10 Intolerable pain

Circle your pain estimate

Please draw the symptomatic areas on the body diagram to the right



Current Problems Difficulty Walking Difficulty Sitting Difficulty Standing Weakness Loss of Function
 Stiffness Difficulty with balance Falling Numbness or tingling Other: _____

How long can you *comfortably*? Sit _____ Stand _____ Walk _____
How long *do* you? Sit _____ Stand _____ Walk _____

Medical History:

I CURRENTLY HAVE OR HAD A HISTORY OF: (Check all that apply)

- | | | |
|---|---|--|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart problems/chest pain |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Pacemaker/Nitro patch | <input type="checkbox"/> Heart attack/MI |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Stroke/TIA | <input type="checkbox"/> Poor circulation |
| <input type="checkbox"/> Asthma/Lung Disease | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Chronic Fatigue Syndrome | <input type="checkbox"/> Hearing problems |
| <input type="checkbox"/> Osteoporosis/Osteopenia | <input type="checkbox"/> Night sweats | <input type="checkbox"/> Dizziness or Blackouts |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Bruising easily | <input type="checkbox"/> Coronary Artery Disease |
| <input type="checkbox"/> Cancer/tumors | <input type="checkbox"/> Recent and sudden weight changes | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Epileptic Seizures | <input type="checkbox"/> Smoking/Tobacco Use | <input type="checkbox"/> Bladder problems |
| <input type="checkbox"/> Psychological/psychiatric problems | | <input type="checkbox"/> Have you ever had any surgery? If yes, please list, with dates. |
| <input type="checkbox"/> Other _____ | | _____ |
| | | _____ |
| | | _____ |

Medical Screening Tests:

Females:

I have had a pelvic exam within the last 12 months Yes No
I have had a mammogram or breast exam within the last 12 months Yes No
I am or may be PREGNANT. Yes No

Males: I have had a prostate exam within the last 12 months Yes No

Exercise: Do you exercise beyond normal activities & chores? Yes No
If yes, what do you do? _____

Please list all your current medications including prescriptions, over the counter medication, vitamins and supplements including dosages. You may attach a separate list if you wish. _____

Home situation: House ___ Apartment ___ Stairs ___ Live alone ___

Need Assistance for: Dressing / bathing ___ Cooking ___ Dishes ___ Laundry ___ Housecleaning ___ Grocery shopping ___

What activities would you like to do now but can't because of your problem? _____

What are your goals with Physical Therapy? _____

Patient Signature: _____ Date _____

*For therapist's use during the initial evaluation: Any information added to this form, by me, has been marked with an **
Signed: _____ Date: _____