

FAMILY/PERSONAL HISTORY

Date: _____

Client's Name: _____ DOB: _____ Age: _____

Race/ethnicity:

- American Indian/Alaska Native Asian Black/African American
 Caucasian/white Hispanic/Latino Native Hawaiian/Pacific Islander
 Multiracial Other/unknown

Language: English understood Interpreter needed Primary language:

Medical Diagnosis: _____ Date of onset: _____

Physician: _____ Date of surgery (if any): _____ Type of Surgery: _____

Past Medical History

Have you or any immediate family member (parent, sibling, child) ever been told you have:

Circle one:			Relation to Client	Date of Onset	Current Status
• Allergies	Yes	No			
• Angina or chest pain	Yes	No			
• Anxiety/Panic attacks	Yes	No			
• Arthritis	Yes	No			
• Asthma, hay fever, or other breathing problems	Yes	No			
• Cancer					
• Chemical dependency (alcohol/drugs)	Yes	No			
• Cirrhosis/liver disease	Yes	No			
• Depression	Yes	No			
• Diabetes	Yes	No			
• Eating disorder (bulimia, anorexia)	Yes	No			
• Headaches	Yes	No			
• Heart attack	Yes	No			
• Hemophilia/slow healing					
• High cholesterol	Yes	No			
• Hypertension or high blood pressure	Yes	No			
• Kidney disease/stones	Yes	No			
• Multiple sclerosis	Yes	No			
• Osteoporosis					
• Stroke	Yes	No			
• Tuberculosis	Yes	No			
• Other (please describe)	Yes	No			

Personal History

Have you ever had:

• Anemia	Yes	No	• Chronic bronchitis	Yes	No
• Epilepsy/seizures	Yes	No	• Emphysema	Yes	No
• Fibromyalgia/myofascial pain syndrome	Yes	No	• GERD	Yes	No
• Hepatitis/jaundice	Yes	No	• Gout	Yes	No
• Hypoglycemia	Yes	No	• Guillain-Barré Syndrome	Yes	No
• Joint replacement	Yes	No	• Parkinson's disease	Yes	No
• Polio/postpolio	Yes	No	• Peripheral vascular disease	Yes	No
• Shortness of breath	Yes	No	• Pneumonia	Yes	No
• Skin problems	Yes	No	• Prostate problems	Yes	No
• Rheumatic/scarlet fever	Yes	No	• Urinary incontinence (dribbling, leaking)	Yes	No
• Urinary incontinence (dribbling, leaking)	Yes	No	• Thyroid problems	Yes	No
• Urinary tract infection	Yes	No	• Ulcer/stomach		
• Varicose veins	Yes	No			

For women:

History of endometriosis	Yes	No
History of pelvic inflammatory disease	Yes	No
Are you/could you be pregnant?	Yes	No
Any trouble with leaking or dribbling urine?	Yes	No
Number of pregnancies _____	Number of live births _____	
Have you ever had a miscarriage/abortion?	Yes	No

General Health

1. I would rate my health as (circle one): Excellent Good Fair Poor
2. Are you taking any prescription or over-the-counter medications? Yes No
If yes, please list: _____
3. Are you taking any nutritional supplements (any kind, including vitamins) Yes No
4. Have you had any illnesses within the last 3 weeks (e.g., colds, influenza, bladder or kidney infection)? Yes No
If yes, have you had this before in the last 3 months? Yes No
5. Have you noticed any lumps or thickening of skin or muscle anywhere on your body? Yes No
6. Do you have any sores that have not healed or any changes in size, shape, or color of a wart or mole? Yes No
7. Have you had any unexplained weight gain or loss in the last month? Yes No
8. Do you smoke or chew tobacco? Yes No
If yes, how many packs/pipes/pouches/sticks a day? _____
How many months or years? _____
9. I used to smoke/chew but I quit _____ Yes No
If yes: pack or amount/day _____ Year quit _____
10. I would like to quit smoking/using tobacco Yes No
11. How much alcohol do you drink in the course of a week? (one drink is equal to 1 beer, 1 glass of wine or 1 shot of hard liquor) _____
12. Do you use recreational or street drugs (marijuana, cocaine, crack, meth, amphetamines, or others)? If yes, what, how much, how often? _____ Yes No
13. How much caffeine do you consume daily (including soft drinks, coffee, tea, or chocolate)? _____
14. Are you on any special diet? _____

15. Do you have (or have you recently had) any of these problems:

Yes

No

- | | | |
|---|---|---|
| <input type="checkbox"/> Blood in urine, stool, vomit, mucous | <input type="checkbox"/> Cough | <input type="checkbox"/> Difficulty swallowing/speaking |
| <input type="checkbox"/> Dizziness, fainting, blackouts | <input type="checkbox"/> Dribbling or leaking urine | <input type="checkbox"/> Memory loss |
| <input type="checkbox"/> Fever, chills, sweats (day or night) | <input type="checkbox"/> Heart palpitations or fluttering | <input type="checkbox"/> Skin rash or other changes |
| <input type="checkbox"/> Nausea, vomiting, loss of appetite | <input type="checkbox"/> Numbness or tingling | <input type="checkbox"/> Unusual fatigue, drowsiness |
| <input type="checkbox"/> Changes in bowel or bladder | <input type="checkbox"/> Swelling or lumps anywhere | <input type="checkbox"/> None of these |
| <input type="checkbox"/> Throbbing sensation/pain in belly or anywhere else | <input type="checkbox"/> Problems seeing or hearing | <input type="checkbox"/> Trouble sleeping |

Medical/Surgical History

1. Have you ever been treated with chemotherapy, radiation therapy, biotherapy, or brachytherapy (radiation implants)?

Yes No

If yes, please describe:

2. Have you had any x-rays, sonograms, computed tomography (CT) scans, or magnetic resonance imaging (MRI) or other imaging done recently?

Yes No

If yes, what? When? Results?

3. Have you had any laboratory work done recently (urinalysis or blood tests)?

Yes No

If yes, what? When? Results (if known)?

4. Any other clinical tests?

Yes No

Please describe:

5. Please list any operations that you have ever had and the date(s):

Operation Date

6. Do you have a pacemaker, transplanted organ, joint replacement, breast implants, or any other implants?

Yes No

If yes, please describe:

Work/Living Environment

1. What is your job or occupation? _____

2. Military service: (When and where): _____

3. Does your work involve:

- Prolonged sitting (e.g., desk, computer, driving)
- Prolonged standing (e.g., equipment operator, sale clerk)
- Prolonged walking (e.g., mill worker, delivery service)
- Use of large or small equipment (e.g., telephone, forklift, computer, drill press, cash register)
- Lifting, bending, twisting, climbing, turning
- Exposure to chemicals, pesticides, toxins, or gases
- Other: please describe
- Not applicable; none of these

4. Do you use any special supports:

- Back cushion, neck cushion
- Back brace, corset
- Other kind of brace or support for any body part
- None; not applicable

History of falls:

- In the past year, I have had no falls.
- I have just started to lose my balance/fall.
- I fall occasionally.
- I fall frequently (more than two times during the past 6 months).
- Certain factors make me cautious (e.g., curbs, ice, stairs, getting in and out of the tub).

I live:

- Alone With family, spouse, partner
- Nursing home Assisted Living Other _____

For the physical therapist:

Vital Signs

Resting pulse rate: _____

Respirations: _____

Blood pressure: 1st reading _____

Oral temperature: _____

Oxygen saturation: _____

2nd reading _____

Position: Sitting Standing Extremity: Right Left