SPECIALIZED
PHYSICAL THERAPY
10118 Maple St. Omaha, NE 68134 | Phone 402.939.7939 | Fax 402.939.7940 | www.PTomaha.com

Patient'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: ________________________

Referring Physician: ______________________________ Date of Surgery (if any): _______________

Past Medical History:
Have you or any immediate family member (parent, sibling, child) ever been told you/they have:

	(Circle One)		Self	Family
Allergies	Yes	No		
Angina/Chest Pain	Yes	No		
Anxiety/Panic Attacks	Yes	No		
Arthritis	Yes	No		
Asthma, Hay Fever, or Other Breathing Problems	Yes	No		
Cancer	Yes	No		
Chemical Dependency	Yes	No		
Cirrhosis/Liver Disease	Yes	No		
Depression	Yes	No		
Diabetes	Yes	No		
Eating Disorder	Yes	No		
Headaches	Yes	No		
Heart Attack	Yes	No		
Hemophilia/Slow Healing	Yes	No		
High Cholesterol	Yes	No		
Hypertension/High Blood Pressure	Yes	No		
Kidney Disease/Stones	Yes	No		
Multiple Sclerosis	Yes	No		
Osteoporosis	Yes	No		
Stroke	Yes	No		
Tuberculosis	Yes	No		
Other (Please Describe):				

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
			Gout	Yes	No
Hepatitis/Jaundice	Yes	No	Guillain-Barre	Yes	No
Hypoglycemia	Yes	No	Syndrome	Yes	No
Joint Replacement	Yes	No	Parkinson's Disease	Yes	No
Polio/Post-polio	Yes	No	Peripheral Vascular	Yes	No
Shortness of Breath	Yes	No	Disease	Yes	No
Skin Problems	Yes	No	Pneumonia	Yes	No
Rheumatic/Scarlet Fever	Yes	No	Prostate Problems	Yes	No
Urinary Incontinence (dribbling/leaking)	Yes	No	Thyroid Problems	Yes	No
			Ulcer/Stomach Problems	Yes	No
Urinary Tract Infection	Yes	No	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

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 (including vitamins)? Yes No
4. Have you had any illnesses within the last 3 weeks (i.e. cold, flu, 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 the 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 use 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. 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)? _______________

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

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

Medical/Surgical History:

1. Have you ever been treated with chemotherapy, radiation therapy, biotherapy, or brachytherapy Yes No
   If yes, please describe: ____
2. Have you had any x-rays, sonograms, CT scans, MRI, or other imaging done recently? Yes No
   If yes, what? _______________ When?______________ Results? _______________
3. Have you had laboratory work done recently (urinalysis or blood tests)? Yes No
   If yes, what? _______________ When?______________ Results________________
4. Any other clinical tests? Yes No
   Please describe: ____
5. Please list any operations that you have ever had and the date(s):

Operation:	Approximate Date:
____	__________________
____	__________________
____	__________________
____	__________________
____	__________________

6. Do you have a pacemaker, transplanted organ, joint replacement, breast implants, or any other implants? Yes No
   If yes, please describe: ____
   ____
7. Within the current year, have you received any treatment at another facility including physical therapy, occupational therapy, speech therapy, or chiropractic service? Yes No

Work/Living Environment:

1. What is your job or occupation? ____

2. Do you use any special supports:
   - □ Back/neck cushion
   - □ Back brace, corset
   - □ Other kind of brace or support: please describe ____
   - □ None; not applicable
3. Fall History:
   - □ 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 2 times during the past 6 months)
   - □ Certain factors make me cautious:
     - □ Curbs
     - □ Ice
     - □ Stairs
     - □ Bathtub transfers
     - □ Other: please list ____

I live:

- □ Alone
- □ With family, spouse, partner
- □ Nursing home
- □ Assisted Living
- □ Other: please describe ____

Please list your main goals for attending therapy: ____

____

____

Please rate your pain on a scaled of 0 (no pain) to 10 (the worst pain imaginable):

Current level of pain	0	1	2	3	4	5	6	7	8	9	10
Least pain (with this injury)	0	1	2	3	4	5	6	7	8	9	10
Most pain (with this injury)	0	1	2	3	4	5	6	7	8	9	10

I prefer my home instructions by:

Written Instruction

Visual Instruction

Auditory Instruction

Hands on Practice