**HISTORY OF CURRENT PROBLEM**

The condition you are starting or continuing therapy for was a result of:

- Vehicle Accident
- Athletic Activity
- Repetitive Motion/Overuse
- Gradual Onset
- Pulling/pushing/climbing
- Other

1. When did the problem(s) begin? Date __/____/____

2. Have you ever had this problem/injury before?  [ ] Yes  [ ] No (go to Question # 6)

3. What did you do for the problem/injury? __________________________

4. Did the problem/injury get better?  [ ] Yes  [ ] No

5. About how long did the problem last? __________________________

6. What are you doing now to improve your problem/injury? __________________________

7. Have you received any therapy this calendar year?  [ ] Yes  [ ] No

Where?

How many visits? PT _____ OT _____ Speech _____

8. What are your goals for therapy?

1. __________________________

2. __________________________

**CURRENT LIMITATIONS: (Check all that apply)**

- Bed Mobility (change position in bed)
- Transfers such as moving bed to chair, chair to commode
- Walking on: _level surfaces _stairs _ramps _uneven terrain
- Difficulty with self-care (bathing, dressing, eating, toileting)
- Difficulty with home management (chores, shopping, etc.)
- Difficulty with community and work activities
  - Out of work/school
  - No participation in recreation or leisure activities
- Lifting
- Communication Problem

**WHERE DO YOU LIVE?**

- Private home  __ 1-story  __ 2-story
- Private apartment  __ 1-story  __ 2-story
- Other __________________________

**WITH WHOM DO YOU LIVE?**

- Alone  __  Child (no spouse)  __  Spouse only  __  Other relatives
- Spouse and others  __  Group Setting
- Personal care attendant  __  Other: __________________________

**DOES YOUR HOME HAVE**

- Stairs, no railing  How many? _______
- Stairs, railing  How many? _______
- Steps to enter  How many? _______
- Ramps  __  Elevator  __  Uneven terrain
- Other obstacles __________________________

**HAND DOMINANCE**

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**FOR WOMEN:** Are you pregnant, or think you might be pregnant?  [ ] Yes  [ ] No

**FOR MEN:** Have you been diagnosed with prostate disease?  [ ] Yes  [ ] No

**GENERAL HEALTH**

- Excellent  __  Good  __  Average  __  Poor
- Activity/Exercise:
  - None  __  1-2 days/wk  __  3-4 days/wk  __  5 days/wk
  - Describe: __________________________

- Do you currently smoke/chew tobacco?  [ ] No
- Yes; Cigarettes/Cigars  ___ # packs/day
- Smoke in the past?  [ ] Yes  [ ] No; Years quit? _______

**Mental Health:** Current level of stress:

- High  __  Medium  __  Low
- Current psych therapy?  [ ] Yes  [ ] No

**FOR MEN/RELATED CONCERNS**

- Are you seeing anyone else for this problem?  (check all that apply)

  - Cardiologist  __  Orthopedist  __  Chiropractor
  - Osteopath  __  Dentist  __  Pediatrician
  - Podiatrist  __  Internist  __  Rheumatologist
  - Neurologist  __  ENT  __  Primary Care Doctor
  - Massage Therapist  __  Obstetrician/Gynecologist
  - Other: __________________________

**WITHIN THE PAST YEAR, HAVE YOU HAD ANY OF THE FOLLOWING SYMPTOMS?**

1. [ ] Back/Neck Pain  [ ] Hearing Problems
2. [ ] Bowel Problems  [ ] Hoarseness
3. [ ] Chest Pain  [ ] Joint Pain/Swelling
4. [ ] Coordination Problem  [ ] Loss of Appetite
5. [ ] Cough  [ ] Loss of Balance
6. [ ] Communication problem  [ ] Nausea/Vomiting
7. [ ] Difficulty Sleeping  [ ] Pain at Night
8. [ ] Difficulty Swallowing  [ ] Shortness of Breath
9. [ ] Difficulty Walking  [ ] Urinary Problems
10. [ ] Dizziness/Blackouts  [ ] Vision Problems
11. [ ] Fever/Chills/Sweats  [ ] Weakness/Arms/Legs
12. [ ] Headaches  [ ] Weight Loss/Gain
13. [ ] Heart Palpitations  [ ] Other

**WHERE DO YOU LIVE?**

- Private home  __  1-story  __  2-story
- Private apartment  __  1-story  __  2-story
- Other __________________________

**WITH WHOM DO YOU LIVE?**

- Alone  __  Child (no spouse)  __  Spouse only  __  Other relatives
- Spouse and others  __  Group Setting
- Personal care attendant  __  Other: __________________________

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  - Neurologist  __  ENT  __  Primary Care Doctor
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12. [ ] Headaches  [ ] Weight Loss/Gain
13. [ ] Heart Palpitations  [ ] Other
What language are you most comfortable speaking with your therapist?
__________________________________________

Would you like an interpreter? __ Yes __ No

Bacharach can discuss my health information with the following persons who are involved in my care:
__________________________________________ 

Please check any conditions you have:  □ None

- Arthritis
- Blood clots
- Blood disorders
- Broken bones/fracture
- Eating Disorder
- Circulation/Vascular
- Depression, Anxiety, Irritability
- Developmental Problems
- Emotional/behavioral problems
- __ Other

Please check any conditions you have and if you are under the care of a health professional for the following:

- Cancer __ Yes __ No
- HIV/AIDS __ Yes __ No
- Diabetes __ Yes __ No
- Dialysis __ Yes __ No
- Underweight? __ Yes __ No
- Dysphagia __ Yes __ No
- Morbid obesity __ Yes __ No
- Multiple sclerosis __ Yes __ No
- Parkinson's Disease __ Yes __ No
- PPN/enteral feeding __ Yes __ No
- Substance abuse __ Yes __ No
- Pressure ulcers/non-healing wounds __ Yes __ No

Allergies:
Check if you ever had the following:

- Medication
- Food
- Environmental
- Latex

Have you had surgery or significant invasive procedures?  Yes __ No

If yes, please describe, and indicate dates:
__________________________________________________

Have you fallen in the past three months?  __Yes __ No

If yes, please describe:
__________________________________________________

Have you traveled outside the United States in the past 30 days?  □ No  □ Yes - please tell us where

Highest grade completed (circle one)

1  2  3  4  5  6  7  8  9  10  11  12
- College/Technical School/Vocational School
- College Graduate
- Advanced/Graduate Degree

Your occupation?

Leisure interests:

Method you learn best:  __ Watching __ Listening
__ Doing __ Having written information

Do you have any customs, religious beliefs, or wishes that might affect care?  __ Yes __ No

Do you have any concerns about physical, emotional, or sexual abuse?  __ Yes __ No

Would you like to talk to someone about your situation?  __ Yes __ No

Please list all known allergies and adverse drug reactions (attach separate sheet if needed)

Please list your current medications and their purposes (pain relief, arthritis, etc):

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List all other medications/purposes: (including over-the-counter medications, vitamins, and herbal preparations)

| __ | __ |
| __ | __ |
| __ | __ |
| __ | __ |

Not taking any medication for this problem/injury __